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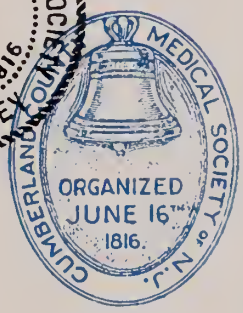
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JOURNAL
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63
1966











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CONTENTS · Pages 1 to 38

EDITORIALS

"... Each Year Adds Something ..." 1
The Sesquicentennial Six 1
"Doctor Means A Learned Man ... Or Does It?" 1
The Journal Salutes 2

ORIGINAL ARTICLES

Sigmoidoscopic Differentiation Of Colonic Bleeding
James Edson, M.D., Paterson 3
Medical Reports for Patients with Heart Disease
I. Richard Zucker, M.D., South Orange 8
Rehabilitation in the Cerebral Vascular Accident
Albert A. Martucci, M.D., Philadelphia, Pennsylvania 11
Review of Gastric Bezoars
Sang Chong Park, M.D. and James S Todd, M D., Ridgewood 17
Community Psychiatry and Pediatrics
Dominick Calobrisi, M.D., Y. S. Kim, M.D. and William E. Ganss, M D., Plainfield 21

STATE ACTIVITIES

Academy of Medicine Meetings 16
Morris County Exhibit 20
William L. Vroom: Half as old as the Society 23
Opticians' Attitude Towards S-2658 24
New Jersey Doctors To Viet Nam 24
Trustees' Minutes: November 14, 1965 25
November 21, 1965 26
Phony Telephone Solicitations 28

BICENTENNALIA 29

ANNOUNCEMENTS 33

OBITUARIES 3[illegible]

RESPIRATORY DISEASE ABSTRACTS 3[illegible]

January, 1966 • Vol. 63, No. 1
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ON THE COVER

In its bicentennial year, the official seal of The Medical Society of New Jersey shares prominence with the official seals of those component societies celebrating their sesquicentennial anniversaries. According to the proceedings of the New Jersey Historical Society ("An Outline of the History of the Medical Society of New Jersey to 1900"), the first county medical societies organized in 1816 were: Somerset, May 21; Essex, June 4; Cumberland, June 6; Middlesex and Morris, June 11; and Monmouth, July 24.

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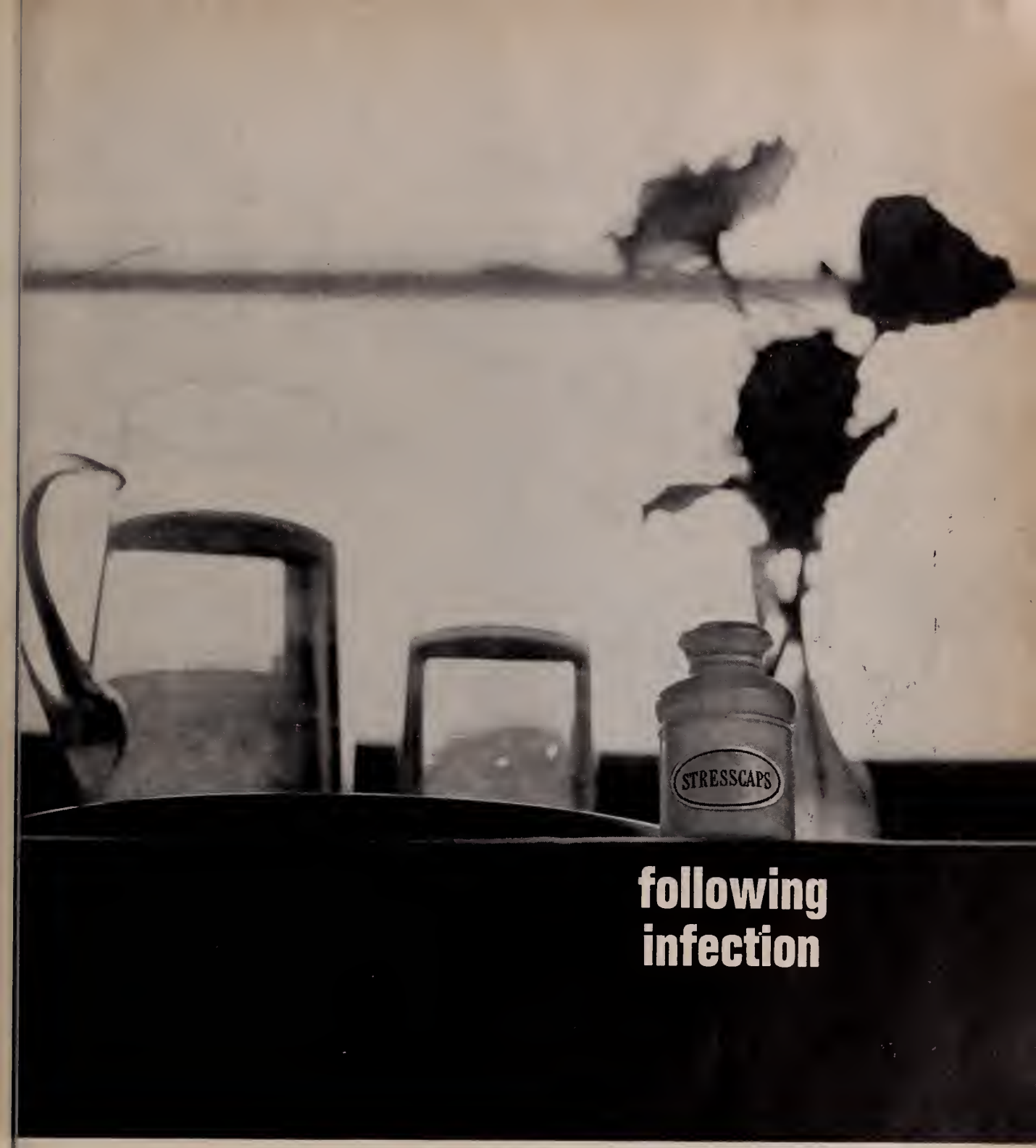
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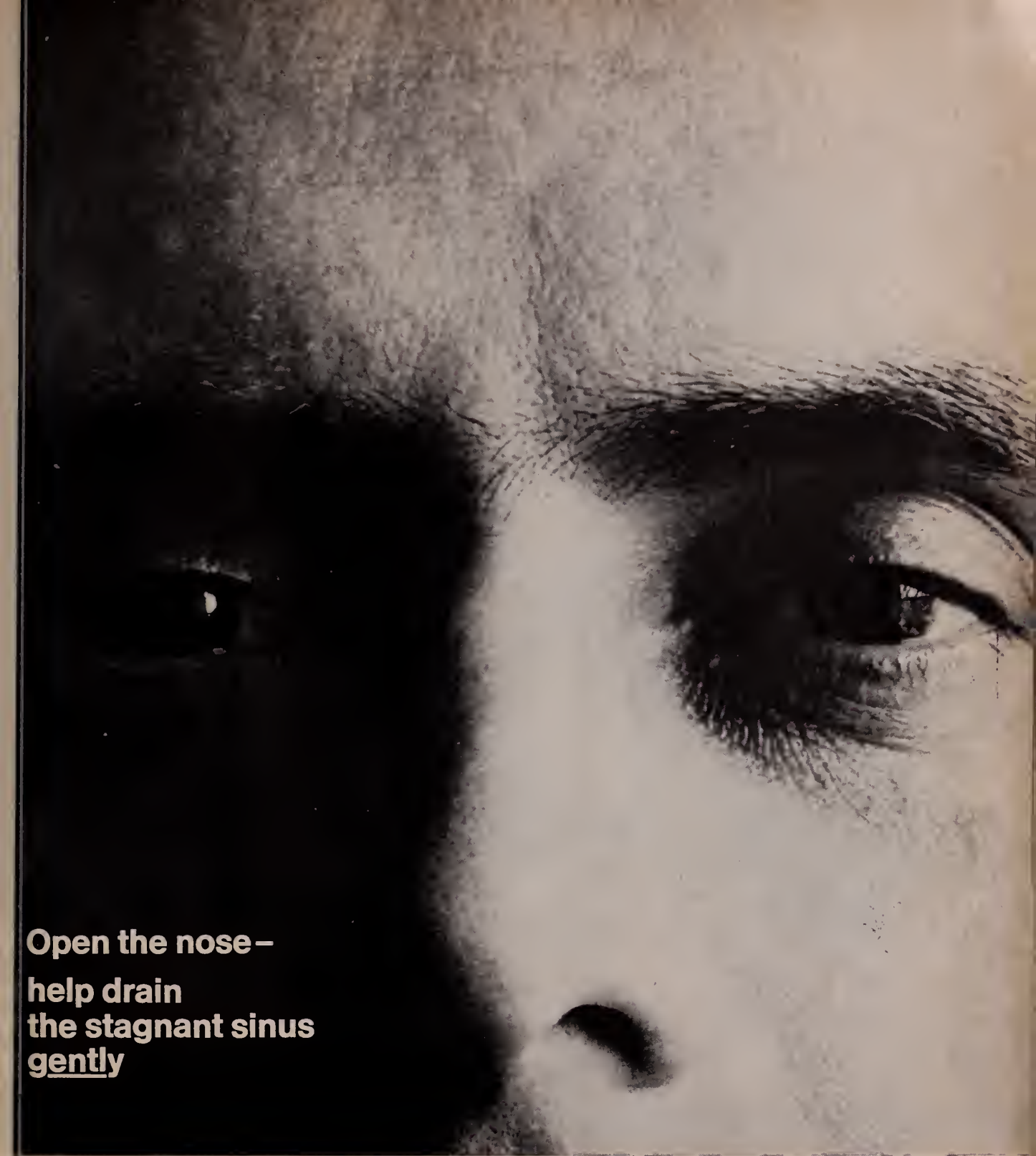
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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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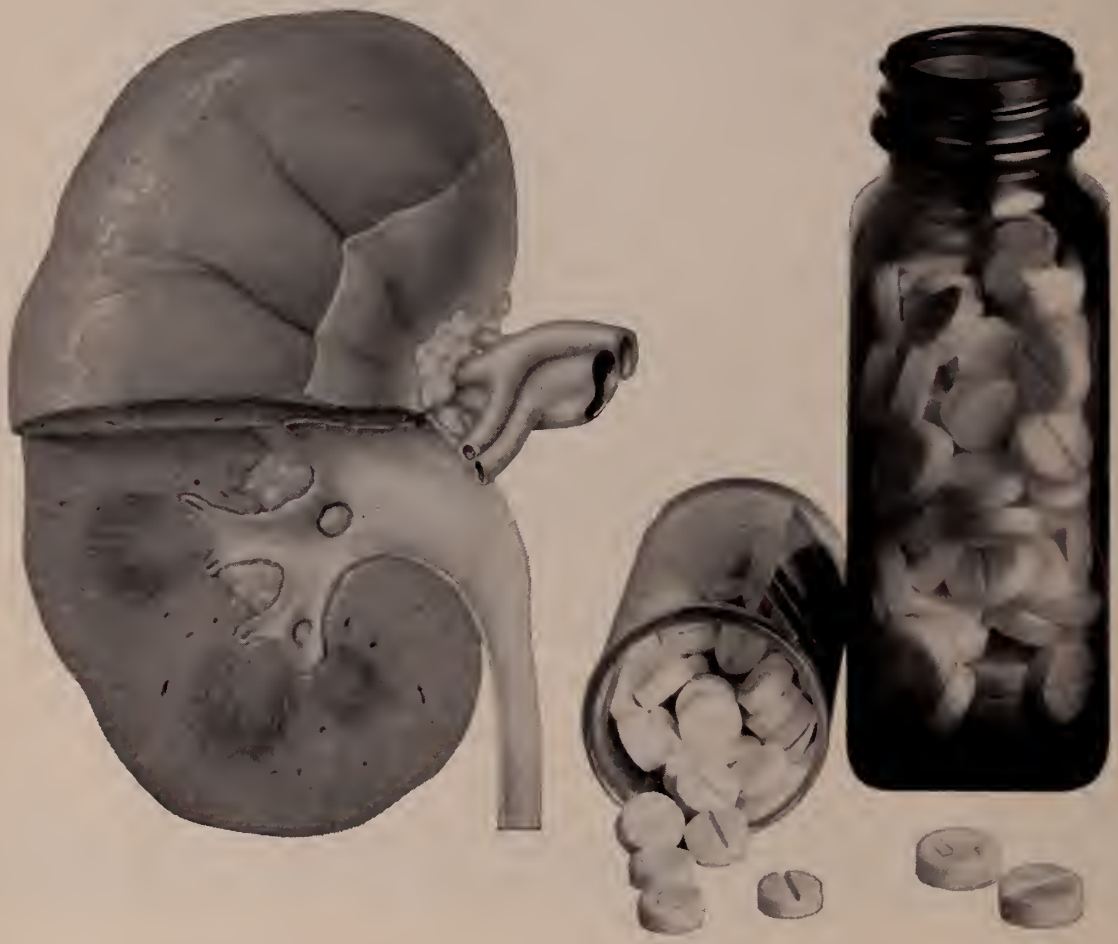
Side effects typical of tetracyclines include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation) and increased intracranial pressure (in young infants). Also, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. Because of reactions to artificial or natural sunlight (even from short exposure and at low dosage), patient should be warned to avoid direct exposure. Stop drug immediately at the first sign of adverse reaction. It should not be taken with high calcium drugs or food; and should not be taken less than one hour before, or two hours after meals.

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arks, V., and Dawson, A.: it. M. J. 1:293, 1965.

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In *men:* in whom trichomonads have been demonstrated, one 250-mg. oral tablet b.i.d. for ten days.

Contraindications

Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precautions and Side Effects

Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

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EDITORIALS

". . . Each Year Adds Something . . ."

In our 200th year, it is interesting to report an item from our first centennial. Abraham Coles, M.D., President of The Medical Society of New Jersey in 1866, delivered his address in poetry. And one of the most moving of his verses was this:

> O Ye devoted to the Healing Art
> By solemn consecration, set apart . . .
> Whose special function 'tis to give relief
> In the dark hour of suffering and of grief;
> Between the living and the dead, to stand
> Where fall the shafts of death on either hand;
> Without one thought of flight, to still maintain
> Perpetual battle with the Powers of Pain . . .
>
> "Knowledge is power," and here 'tis power to save,
> A power like God's to rescue from the grave.
> Each Year adds something — many things ye know
> Your sires knew not a Hundred Years ago;
> Art grown to more, your sons will higher climb,
> And make the Coming Centuries sublime . . .

And so in a world without penicillin, x-rays, or artificial heart valves, they had, at least, faith that "each year adds something." So it has, and our "art has grown to more." But it is up to us to make the "coming centuries sublime."

Our professional sires gave us this magnificent heritage. Now it is up to us.

The Sesquicentennial Six

Along with our State Society's bicentennary in 1966, six of our county societies will be setting up birthday cakes with 150 candles each. And so we join the brethren in singing "Happy Birthday" to county societies in Cumberland, Essex, Middlesex, Monmouth, Morris, and Somerset.

To The Medical Society of New Jersey, any 150-year old society seems a mere infant. Actually, though, 1816 was a long, long time ago, as American institutions go. That was the year of the exiling of Napoleon to St. Helena. In our own country, it was the "Era of Good Feeling." James Madison and his lovely wife Dolly moved back to the rebuilt Executive Mansion (painted white to cover the scars of its burning by the British in 1812, and since then called "The White House"). Henry Clay and John Calhoun were the doughty debaters in the small U.S. Senate. Indiana had just been admitted to the Union. And it was in that year that Joseph Bonaparte moved to New Jersey. Our local physicians made their calls on horseback, and they didn't have to worry about the untoward effects of potent antibiotics. Doctors were community leaders then—many were judges, clergymen, congressmen, and civic officials of all types. (Dr. William Newell of our Monmouth County Medical Society was born in that year, and was Governor of New Jersey in 1857.)

So congratulations to our six sesquicentennial societies! The first 150 years are the hardest.

"Doctor Means A Learned Man . . . Or Does It?"

If you can believe their officials, American medical schools are looking for the well-rounded college citizen, not the scientific grind. That, at least, is what they say. The official position of most American medical schools might be paraphrased this way: "We can teach our students medical science. We can't teach them to be well-rounded human beings—our medical school curriculum is too busy for that. So we'd like students who have been exposed to history, philosophy, foreign language, and the humanities in the university before they enter medical school."

An examination of the catalogues of our 89

medical schools shows that the only premedical courses demanded by more than half the schools are chemistry, physics, English, and biology. In fact, fewer than half the schools even recommend (much less demand) "liberal arts" or "humanities" courses.

All but seven of the 89 schools insisted that candidates take the Medical College Aptitude Test and, presumably, gave considerable weight to this examination. The MCAT is heavily weighted with questions on the natural sciences.

One would think that this premedical moulding is purposely designed to keep the well-rounded scholar out of the profession. In this connection, an interesting observation was made by Dr. George E. Miller of the University of Illinois College of Medicine. His studies indicated that students of superior capacity often fail their first year. And in most medical schools, there is no second chance. One "flunk out" is all. Dr. Miller found that medical school tests and examinations put a premium on the parrotting of what the teacher, or the book, says. Rewards went to the students with perfect recall. Analytic or critical thinkers were likely to be in trouble with the traditional type of examination or test. Dr. Miller confessed that he was unpopular among his faculty brethren at the University of Illinois College of Medicine, since his colleagues did not take kindly to the thesis that what they had been doing for years was wrong.

In another medical school, a senior examination had this multiple choice question: "A melanoma is a particularly malignant because: (a) it metastasizes swiftly through the lymphatics; (b) it consists of very small cells; (c) the patient thinks it is only a wart and often neglects it until it is too late; (d) the melanin it contains is especially irritating; or (e) it occurs chiefly in young and susceptible patients."

The only acceptable answer was (a). A more imaginative student said that (c) was the better answer; he was told that in an objective test, only objective answers should be given. The student who earned the "right" mark was the one who unimaginatively repeated the statement in the book—about metastasis. The student who thought of the total patient, and how he would emotionally react, was penalized for his breadth of thought.

American doctors often look back nostalgically at the days when the physician was, along with the clergyman and the school teacher, part of the intellectual leadership of the town. The decline of the scholarly image has, understandably, made many of us unhappy. And often, we don't seem to know what pushed the doctor off his pedestal. Perhaps this decline of the scholarly-intellectual-academic flavor has something to do with it.

The Journal Salutes

THE JOURNAL dresses for the occasion of our bicentennial year. Our Society is the oldest in the nation. The cover has been designed to reflect this with the large seal. The smaller seals represent the counties that are 150 years old. Many things are planned for our JOURNAL this year, including a special commemorative issue in August.

Two hundred years of continuous association of medical practitioners dedicated to lofty ideals, high standards of professional quality, and the application of these to the ever-changing needs of our people are contributions worthy of recognition. The Society's role in the steady improvement of the distribution of medical care, in the interpretation of professional ethics, and in the promotion of good community relationships has helped create an environment where everyone's interests can coincide effectively for the general welfare of all.

THE JOURNAL salutes and records past achievements and looks forward to even greater accomplishments as the future unfolds.

George B. Sharbaugh, M.D.
Chairman
Publication Committee

ORIGINAL ARTICLES

In these few pages, Dr. Edson offers us a compact little handbook on the differential diagnosis of rectal bleeding as interpreted sigmoidoscopically

Sigmoidoscopic Differentiation Of Colonic Bleeding*

James Edson, M.D./Paterson

Certain diseases causing colonic bleeding may be *diagnosed* by sigmoidoscopy. In other conditions, the weight of the sigmoidoscopic findings contribute significantly to the diagnosis. In this context, the phrase "colonic bleeding" refers to any transanal bleeding from a site proximal to the dentate or ano-rectal line, but distal to the ileo-cecal valve.

From 75 to 80 percent of the lesions of the large bowel are within reach of the sigmoidoscope. Sigmoidoscopy therefore should be accorded first place as a special diagnostic measure, not overlooking the occasional case in which the history may indicate that stool studies be given priority or at least equal consideration. We have all seen roentgenologic studies done as the first and (on a few occasions) as the only study with tragic consequences to some patients.

In most instances, roentgen studies of the colon should be contingent upon what is learned from sigmoidoscopy. There are two other reasons for giving proctoscopy first priority:

(a) The relative simplicity of preparation for sigmoidoscopy compared with barium enema preparation; and (b) The true nature of the lesion within reach of the scope is more likely to be determined by *direct* vision than by fluoroscopic or roentgenologic *interpretation*. In colonoscopy and in examination of colonic stomas, the sigmoidoscope is often of great diagnostic and prognostic value.

The diseases responsible for colonic bleeding may be classified in four categories:

1. Inflammatory lesions of infectious origin.
2. Benign epithelial tumors.
3. Malignant tumors of the colon.
4. Lesions beyond the reach of the sigmoidoscope with sigmoidoscopic interpretation of bleeding.

Inflammatory Lesions

This group is comprised mainly of diseases of bacterial and parasitic origin. Patients present themselves at the doctor's office with the complaint of bleeding or bloody diarrhea. Upon sigmoidoscopy, one finds varying degrees of inflammation of the mucous membrane of the rectum or sigmoid, or both. This is generally recognized as some form of ulcerative proctitis or sigmoiditis. Colitis and sigmoiditis rarely exist without involvement of the rectum.

Chronic Ulcerative Colitis or proctosigmoiditis is a disorder in which a diplostreptococcus is often found. This is of questionable etiologic significance. In this disease (characterized by remissions and exacerbations) sigmoidoscopic examination is helpful, especially in the early diagnosis. In 95 percent of these cases, the dis-

* Read May 19, 1965 at Atlantic City, before the Gastroenterology, Proctology, Radiology, and Surgery Joint Session of The Medical Society of New Jersey.

ease starts in the rectum. Early in the disease the ulcers are numerous and of small size. The surrounding mucosa is diffusely inflammed and granular. This hyperemia gradually fades into normal mucosa as the sigmoid is approached.

As the disease progresses, edema of the mucous membrane ensues and may pit on slight pressure from the sigmoidoscope. The walls are easily traumatized and bleed at this stage. Minute yellow abscesses appear through the mucous membrane, which later ruptures to form ulcers adding a moth eaten appearance to the already granular lining. Eventually, with secondary infection, the denuded areas become confluent to form ragged ulcerations. With healing, areas of scar tissue may be observed. The bloody purulent discharge in ulcerative colitis is seen mixed with the stool.

Amebiasis is a parasitic disease due to the Endamoeba Histolytica. It is said to affect between 10 and 15 percent of the United States population. Often it is not diagnosed by "routine stool studies," primarily because it takes an expert parasitologist to identify the cysts or trophozoites. However, in patients presenting the bloody diarrhea know as *amoebic dysentery,* the sigmoidoscopic picture may vary from areas of erythema to areas of ulcerations. Experts assert that from 30 to 50 per cent of these patients have ulcers within reach of the sigmoidoscope. At first, a papular spot or millet-seed sized elevation may be seen with a yellow or white point of necrosis which soon becomes an ulcer. These ulcers usually discrete, are commonly distributed on the valves of Houston and prominent folds of the bowel wall.

The ulcers have irregular undermined edges. They are troughlike, round or oval in shape, and exhibit a grayish necrotic deep base. With secondary infection, the ulcers become atypical. The discharge is usually less purulent than it is in ulcerative colitis. In children with acute dysentery, a thin pea-soup green mucoid discharge is often found which, together with scrapings of the ulcers, frequently reveals the trophozoite of amebiasis if examined immediately.

Bacillary proctosigmoiditis or Bacillary dysentery is produced by a gram negative bacilli. Viewed sigmoidoscopy, the ulcers are not characteristic, but appear somewhat superficial and dominate the folds or ridges of the mucosa. The ulcers are usually sharp. The base is shallow and brown in color. Scattered grayish yellow placques of necrotic mucous membrane may be seen. When wiped with an applicator, these placques leave a raw bleeding area.

Swabs or aspirates of this material are excellent for micro-examination and culture. The mucosa between ulcerations appears normal in this disease.

Factitial or Radiation Proctitis may cause daily bleeding with defecation.

Sigmoidoscopy reveals a pearly placque situated on the anterior rectal wall surrounded by telangiectasis. In some cases, a large zone of ulceration is surrounded by scar and telangiectasis. The size is proportionate to the amount of radium used. Repeated biopsies may be necessary to rule out malignancy where the process encircles the rectum.

Diverticulosis is the term used to denote sacculations along the extraluminal wall of the gastrointestinal canal. Diverticulitis is a morbid condition, denoting inflammatory changes in these sacculations. In 85 percent of the cases, the site of election is the flexure of sigmoid colon. Hence, many cases of diverticulitis and diverticulosis can be diagnosed by sigmoidoscopy. Buie[8] has listed five signs, through the use of which he was able to diagnose two-thirds of the cases. These are:

(a) Limited mobility of a segment of the bowel associated with limited mobility of adjacent structures.

(b) Angulation of the bowel due to inflammatory immobilization making it impossible to pass the sigmoidoscope beyond that point.

(c) Reduced lumen and adherent mucosal folds due to contracture of fibrous tissue infiltrating bowel wall. Occasionally folds become edematous.

(d) Sigmoidal sacculations, shallow pouches or depressions, may extend completely around the wall of the bowel, with intervening ridges best visualized when the bowel is distended with air.

(e) Actual view of the openings of the diverticula. These signs may be seen separately, but usually occur in combination.

(f) In some cases of diverticulitis, a mass may be felt in the left lower quadrant; and sometimes, in acute cases on digital examination, an indurated mass can be palpated at the rectosigmoid juncture.

Schistosomiasis or Fluke Disease is a parasitic infestation that occasionally produces a proctosigmoiditis with bleeding. When one seees an ulcerated area in a thickened and papillomatous mucosa with an excessive mucous, one must suspect schistosomiasis. Biopsy or swabs of the mucosa will often reveal ova possessing characteristic lateral spines. In long standing cases, extensive fibrosis of the colonic submucosa with nodular formation is seen.

Acute or chronic catarrhal proctitis is an occasional cause of bleeding. These are due to "worms" scientifically designated *helminths.* The five commonest parasites in this category are:

Ascaris lumbricoides or round worm.

Oxyuria vermicularis or pin worm.

Tinea Saginata or tape worm.

Ankylstoma or hook worm.

Trichus trichiura or whip worm.

Less common helminths are *Balantidium coli, Trichimonas hominis, Coccidium hominis, Giardiam lamblia,* and the group of *pseudomenas.*

Sigmoidoscopically, the worms (or segments of the worms—i.e., tapeworms and so on) may be seen. Scrapings of the mucosa or stool studies may reveal the responsible parasites. In the acute stage, the highly colored edematous mucosa has scattered sticky plaques of mucoid material resembling a pseudomembrane. On digital, the mucous membrane feels soft and doughy. In the chronic stage, two types exist:

(a) The hyperbrophic. In the chronic hyperbrophic stage (in contrast with the acute stage) the mucosa is pale with a whitish secretion covering the mucosa, which when swabbed or wiped off leaves a granular surface.

(b) In the atrophic type, the mucous membrane feels dry and inelastic and proctoscopically appears rough, granular, and bleeds easily. Erosions, ulcerations, and necrotic membrane are often noted.

Tuberculous sigmoiditis is usually secondary to pulmunary tuberculosis. This is seen in about 13 percent of people with tuberculosis. Bleeding, usually slight, is secondary to ulcerations that form from tubercle breakdown. The tubercles coalesce to form large irregular ulcers that are oval or eliptical usually lying transverse to the long axis of the gut. They have a gray worm eaten base elevated with tubercles and slightly thickened and undermined edges. The base is covered with mucopurulent discharge early, and later with a gray dirty inseparable slough. The discharge from the ulcers is thin, blood tinged, and has a fetid odor. In prolonged diseases with fibrous contracture, strictures may be seen.

Syphilitic proctitis is rare, but must be thought of as a secondary or tertiary manifestation of syphilis. The ulcers may appear to be "punched out." Edges are sharply defined, bases are indurated. These lesions seem "leathery" or parchment-like.

An occasional late luetic manifestation is the rectal gumma. It is usually a painless, egg-shaped mass with a purple-blue color. Gummata may bleed. Diagnosis is confirmed by biopsy.

Gonorrheal proctitis is also rare and is found chiefly in females. Usually only the lower three inches of the rectum mucosa are involved. Generally, the mucosa is acutely inflammed, edematous, and dark red. The surface has scattered areas of erosions which possess a pungent odor. In chronic cases, ulceration and bleeding can occur.

Benign Epithelial Tumors

Internal hemorrhoids represent the commonest cause of rectal bleeding. Each hemorrhoid is a soft, red (or bluish-red) vascular tumor. Typically, we would see three primary internal hemorrhoids. Hemorrhoidal bleeding may mask bleeding of more serious cause, so that proctosigmoidoscopy is an absolute "must" in a case presumed to be "bleeding hemorrhoids."

Adenomatous polyps, sigmodoscopically, may appear single or multiple, sessile or peduncu-

lated. They are lobular glistening growths, pale pink to red in color. They begin as small mucosal elevations, well circumscribed 1 to 2 millimeters in diameter, and seldom bleed before reaching the 10 millimeter size. Polyps are the most common pathogenic lesions in the rectum or sigmoid. They are seen in 10 to 12 percent of all patients sigmoidoscoped. In the Peutz-Jeghers Syndrome, polyps are found in association with pigmentation of the lips in some patients.

Polyps in this disease, though often in the colon, are more commonly found in the jejunal portion of the small intestine.

Villous tumors are seen sigmoidoscopically as soft epithelial masses, globular in shape, soft and spongy, red in color, usually of very large size with projecting villi that constantly secretes mucus, bleed easily, and have a tendency toward malignant degeneration. The common age group is between 35 and 55. This is a rare lesion.

Multiple or familial polyposis is a serious disease of early adult life. The most common sites are the rectum and sigmoid. Proctosigmoidoscopically they are seen as multiple sessile and pedunculated polyps, movable elastic, shiny and reddish purple. These polyps seem to have an inherited tendency toward malignancy. The urgent need for early colectomy and ileosigmoidostomy must be impressed upon these patients.

Pseudopolyps resemble polyps. They are polypoid mucosal lesions found in about two-thirds of the patients with chronic ulcerative colitis. They are manifestation of long standing chronic inflammatory disease. Sigmoidoscopically, they are seen with other features of chronic ulcerative colitis.

Endometriosis of the rectum or sigmoid is a rare lesion seen in women usually between the ages of 25 to 45. Sigmoidoscopically, it appears as a small polyp or tuft of granulation tissue on anterior surface of the rectum or sigmoid. Bleeding is not common, but can happen, notably at the time of the menses.

Malignant Tumors of the Colon

Adenocarcinoma is the most frequently seen malignancy of the colon. It is derived from glandular epithelium. Others less frequently encountered are the connective tissue tumors, the sarcomas, malignant melanoma, fibrosarcomas, lymphosarcomas, leimyosarcomas, and other cytologic variations.

Sigmoidoscopically, malignant tumors are seen more often sessile rather than pedunculated. Typically, the neoplasm is an irregular nodular mass with a firm broad base that is indurated and fixed. As it enlarges, it becomes a fungating cauliflower-like mass. In color, it is dusky-rose. The ulcerated center is deep, the base angry and necrotic with rolled everted edges. Malignant tissue is almost as friable as chopped meat. This area of friable tissue is the best site to biopsy.

Though carcinoma is a common cause of persistent colonic bleeding and may on occasion hemorrhage, it must be remembered that many small or early carcinomas do not bleed.

Lesions Beyond The Reach of the Sigmoidoscope

In about one percent of the patients examined, the picture will be normal except for the finding of blood or bloody mucus, or blood mixed with water or stool coming from beyond the reach of the sigmoidoscope. With few exceptions, on further investigation, a polyp or carcinoma would be found to be the cause of bleeding.

With the use of suction through the sigmoidoscope (for patients with episodes of *massive* bleeding), valuable observations can be made about the character of blood, the volume and rate of bleeding. These observations charted in conjunction with pertinent laboratory data, adequate history, physical and roentgen studies will help immensely in determining the level of bleeding.

Hematochezia means passing rectally bright red blood with or without clots. In adults, it is usually indicative of moderate or severe

colonic bleeding. Only rarely is such bleeding likely to be accompanied by shock.

Melena vera describes coal black shiny "old" blood, sticky and firm, resembling tar, having a nauseating foul smelling odor. Stools of this type result when a large volume of blood traverses the small bowel and colon slowly, thereby losing most of its water content through absorption causing some hemodilutions to the circulating blood.

Pseudomelena describes a black stool that superficially resembles melena. It is not as shiny, sticky, or firm. On close examination it is seen to have a dark red sheen. Against a white background, a narrow red zone may be seen around the periphery. This is typical of moderate bleeding of the right colon. A similar hemorrhage from the left colon would produce hematochezia (bright red blood) and in the early stages of bleeding usually not associated with shock.

The factors of rate, volume, and level of colonic bleeding govern the graduations between pseudomelena and hematochezia. Critical appraisal of these factors in conjunction with a vigorous diagnostic approach will often help avoid the tragic mistake of surgically attacking the wrong end of the gastro-intestinal tract when conservative measures fail to control the bleeding.

If surgery is unavoidable, a sterile sigmoidoscope may be used in colonoscopy in conjunction with segmentalizing technics with special intestinal clamps. Unfortunately, this is not without hazard. In the partly exsanguinated patient (all too often, particularly with colonic bleeding as opposed to upper gastro-intestinal bleeding) the active bleeder becomes inactive during surgery.

In clinically silent, massive colonic bleeding, diverticular disease and polyps are most often indicated. In diverticular disease, diverticulosis is more often blamed than diverticulitis. Occasionally carcinoma, and more rarely, single non-specific ulceration, telangietases, and hemangiomata, varices (especially in cirrotic patients), ruptured aneurysm, and vascular occlusions may produce hemorrhage.

Conclusion

With a practical approach, an attempt has been made to document the importance of sigmoidoscopy in the differention of colonic bleeding.

Obviously, there are other diseases and lesions that are responsible for transanal bleeding of colonic origin, the source of which can be determined only after complete and vigorous diagnostic studies. However, in most patients, the relatively simple diagnostic maneuver of proctosigmoidoscopy will reveal the cause and source of bleeding.

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480 Park Avenue

Your patients may not be able to get full benefits, because of shortcomings in the medical reports. Here are some suggestions about avoiding these errors.

Social Security Medical Reports for Patients With Heart Disease

I. Richard Zucker, M.D.*/South Orange

Heart disease is the commonest cause of disability among people who qualify for social security disability benefits. Cardiac disorders are responsible for inability to work in over 25 percent of disabled workers drawing benefits. Medical reports from attending physicians are of primary importance in reaching decisions in these cases.

Each year, New Jersey physicians prepare about 25,000 medical reports for patients who have applied for payments under the disability program. Half of these initial reports do not furnish clear enough findings to permit a determination as to whether the patient is unable to engage in any substantial gainful activity, the definition of disability contained in the Social Security Act. We know that the treating physician often has more information in his records than he puts on his initial report. When he understands what type of evidence is needed, his reports will be more complete. A good initial report saves time by avoiding the need for further contacts for additional information.

Disability claims are decided by a State agency in the claimant's home state under a Federal-State agreement. In New Jersey, the Disability Unit of the Rehabilitation Commission makes such determinations. An evaluation team composed of a physician and a vocational counselor must decide whether a patient is unable to perform substantial work. The reviewing physician (who is usually in private practice and serves on a part-time basis) does not examine the patient personally. He depends on your reports and on other written evidence in the claims file for information concerning the severity, onset, and duration of the impairment, and the claimant's remaining functional capacity. Based on this written evidence he must decide two things: whether the patient has an impairment that qualifies him for benefits and whether, with appropriate rehabilitation services, the patient could regain his capacity for self-support. The possibility of rehabilitation is always considered regardless of whether the patient qualifies for disability payments.

As attending physician, you can help to insure that your patient receives a prompt and equitable decision on his claim by submitting a carefully documented and complete medical report. This includes a detailed and meticulously dated history, specific physical findings, laboratory data and clinical course, diagnosis, and prognosis. Remember this: in reporting on a patient's condition, the physician is not obliged to use the [standard] social security medical report form furnished him. The form is intended chiefly as a guide to the kinds of medical information needed. *Narrative reports on the physician's own stationery or photo-*

* A local internist, Dr. Zucker is a medical consultant for the Disability Section of the New Jersey Rehabilitation Commission.

copies of his records are not only acceptable but preferable.

The following information may prove helpful to the physician who uses the report form.

Physical Measurements: Height and weight are of value in the overall assessment of the patient, and may reflect such changes as obesity or emaciation. Obesity, for example, may help to explain dyspnea or heart shape in a suspected cardiac case.

History: Since the determination of disability must cover a specific period, dates are of the utmost importance for all historical events. This is particularly true in insidious conditions, such as heart disorders. Here the evaluation team must establish when the condition became so severe that work was impossible. The medical report should describe the logical progression of medical events through a detailed chronologic account of the natural history of the patient's symptoms, showing onset and course of the condition. Have infarctions occurred? If so, say when. In noting chest pain and breathlessness, relate these symptoms to time of onset and to how they are related to exercise.

Present Condition: Report (a) patient's symptoms and (b) your findings in sufficient detail to give the doctor in the state agency a vivid picture of your patient's limitations. The findings should include both the positive and negative results of the examination if they pertain to or influence the final diagnosis or the assessment of the patient's remaining capacities. The dates of x-rays, electrocardiograms, blood work, and other laboratory tests should always be shown.

Diagnosis: All major diagnoses should be listed. Though a single impairment may not be severe in itself, the aggregate of a patient's several impairments may be incapacitating.

Treatment and Progress: Pertinent information is needed to determine whether and how the patient is being treated; and what has been, or can be expected to be, the therapeutic response. The dosage and frequency of all medication should be shown.

Dates of treatment are significant since the time of the first visit in relation to the reported onset of disability (as well as the frequency of visits) may suggest the severity of illness until the time medical aid was sought, and during the period of treatment. The date of the most recent examination correlates the validity of the findings in relation to the date of application. It is apparent that an examination performed weeks or months earlier would not ordinarily describe the patient's medical condition at the time of application.

The attending physician should also show the prognosis, and any limitations the impairment places on the patient's activity. A laborer engaged in heavy arduous work might be disabled by a heart condition, while a skilled person with extensive experience in a desk job could work even though his impairment caused greater phyical limitations than did the laborer's.

On the reverse of the medical report form, space is provided for more specific information on principal impairments.

In evaluating patients with cardiac impairments, a precise description of the patient's condition is helpful. If possible, use the etiologic, physiologic, and anatomic terms of the functional and therapeutic classification of the American Heart Association.

Class:

I. Ordinary physical activity causes no discomfort; hence, no limitation of activity.

II. Ordinary physical exertion causes discomfort; hence, slight to moderate limitation of physical activity.

III. Less than ordinary activity causes discomfort; hence, marked limitation of activity.

IV. Inability to carry on any physical activity without discomfort.

Class:

A. No restriction of physical activity

B. No restriction of normal physical activity, and avoidance of unusually severe or competitive efforts.

C. Moderate restriction of ordinary activity and elimination of all strenuous activity.

D. Marked restriction of ordinary activity.

E. At complete rest or confined to bed.

This section should also include information about heart size as determined clinically, fluoroscopically, or on x-ray. Serial blood pressure readings are here reported, and the location and severity of edema noted. If dyspnea and/or angina is present, they should be described in terms of how far the patient can walk, or how many stairs he can climb before symptoms occur. A good description of the amount of exertion required to produce angina and/or dyspnea is more useful than general terms such as mild, moderate, or severe.

Sometimes a physician feels obligated to draw a conclusion as to his patient's "disability" from his findings. Remember, though, that the attending physician is asked only for *objective* medical data. Although his interpretations and diagnostic conclusions are helpful, he is not to be put in a position of having to determine whether his patient is "disabled" under the terms of the social security law. This decision, in addition to the medical impairment, must take into consideration specific qualifying requirements in the law.

The importance of the information that the treating physician is in a position to furnish cannot be overemphasized, for without this information, a determination is difficult. An initial report with sufficient details to permit the reviewing physician in the state agency to assess the patient's functional capacities benefits everyone involved: the attending physician need not be asked for additional information, the reviewing doctor in the Disability Unit can evaluate the case promptly, and the patient receives the decision on his claim—and benefits if he is eligible—as speedily as possible.

236 South Orange Avenue

Nurses on Horseback

Did you know that in some rural parts of the United States, nurses still travel on horseback through mud and snow to care for their patients? The name of this "nursing cavalry corps" is the Frontier Nursing Service.

We learned of this unusual, yet extremely dedicated, corps of nursing personnel through Incarnate Word Hospital, St. Louis, Missouri. One of the hospital's R.N.'s is planning to become a Frontier Nurse.

The Frontier Nursing Service is an organization operated much like a public health unit. Although FNS is not a new organization, not much is known of it because it operates in the backwoods area of Kentucky.

The main occupation of those served by Frontier Nursing is coal mining. Once a thriving industry in the area, only a few mines are now in operation and the main source of income to these rural communities has dwindled considerably. Poverty and all of the accompanying medical and social problems provide the traveling nurses with plenty to do.

To become a Frontier Nurse, applicants must go to London, England, for a course in midwifery. From there, they go to Kentucky to complete their training.

Nurses are stationed in pairs at five outpost centers. Each team is given a house with treatment center, a barn, a jeep, and two horses. From this center of operation, the Frontier Nurses care for patients who come to them for treatment and call on those unable to travel to the center.

From *Pulse*, S. M. Edison Chemical Co. ("Dermassage") issue of April 1965.

Motivation, consistent rehabilitative efforts, and sound emotional attitudes are the keys to success in post-apoplectic rehabilitation.

Rehabilitation in the Cerebral Vascular Accident*

Albert A. Martucci, M.D.†
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Until recently, physical rehabilitation measures in the treatment of strokes had been largely directed to the part of the body where function has been disturbed. Little effort had been directed at the lesion in the brain. But during the last ten years there has been a noteworthy change in the attitudes of physicians and families towards this. The use of drugs and regulated electrolyte balance has decreased the incidence of strokes. However, despite some successes, strokes do occur with resultant disability. For this we must have the understanding and reassurance from the physician and family support.

If brain surgery is not indicated, if the stroke and disabilities are present, if death has not occurred—what then? Where do we go? Anticoagulants and other medications will be evaluated by the internist.

Within twenty-four hours after the stroke has occurred, if the patient is out of shock physical treatment should be begun to help restore use of affected extremities. The arm or leg concerned should be put through a range of joint motion. The therapist assists the patient at first. Later he encourages his own active movements by muscle re-education. The physical therapist should work under the direct supervision of the physiatrist. These movements are done two times daily for 10 minutes, depending upon the activity tolerance of the patient. Also, determining factors as to the amount of physical movements depend on the patient's age and the medical status prior to and after the stroke.

Institution of bedside physical medicine within twenty-four hours after the initial episode gives the patient a maximum return of function, an early willingness to cooperate, and a positive outlook towards recovery. Also, the introduction of active and passive movements at bedside twice daily for 10 minute periods makes the patient fully aware of his or her limitations and gives the therapist the opportunity to give daily doses of incentives.

The terms "good nursing care" and "adequate physical medicine" are superfluous.[1] Rehabilitation in stroke depends on a planned program which we have sustained in the various hospitals. The schedule is as follows. As soon as feasible, the patient is sent to the department of Physical Medicine and Rehabilitation and is given the following program morning and afternoon:

(1) Transcerebral diathermy (depending on blood pressure)

(2) Active and passive motion to affected parts and frequent turning of patient for prevention of decubiti

(3) Tilt Table (Standing Table)

(4) Weight bearing with assistance

(5) Walking with assistance

(6) Electrical stimulation to affected parts

(7) Speech therapy if needed

* Read by invitation May 17, 1965 at the Annual Meeting of The Medical Society of New Jersey in Atlantic City.

† Died June 7, 1965.

(8) Muscle re-education of affected parts and range of joint motion to all extremities

(9) Bladder and rectal training program

(10) Occupational activities to encourage use of extremities and finger movements for self care and activities of daily living.

The immediate institution of a program of this kind will give the patient no time to lapse into uselessness and self pity. In addition, the aphasic patient or the one whose mental ability has been partly impaired will be stimulated to work, by being placed in an atmosphere that is conducive to work. This applies equally well to the patient who is not motivated. There will be similarly paralyzed people on all sides of him. Their favorable attitudes can be one more psychologic placebo for the patient.

The second important factor to be considered is the motivation and emotional attitude of the patient. This is the key to the success of the therapy program. The patient's muscles and joints can be kept limber and working by immediate physical medicine; but his ultimate success depends on his *willingness* to work and his *desire* to get well. His success also depends on the attitude of the family, and certainly upon all the personnel who come in contact with him and their willingness to continually encourage him. The atmosphere of group therapy is a powerful stimulus to encourage positive attitude on the part of the patient.

The physician, the family, and the patient himself are constantly looking for evidence of improvement as shown by the learning of new actions and activities. In Physical Medicine, the cooperation of all departments in the rehabilitation of a stroke patient makes this possible.

In occupational therapy the patient is taught a certain number of activities of daily living. The evaluation first made by the physiatrist and the occupational therapist will stress the muscular movements of the stroke patient. The patient is taught to wash himself, transfer from the bed to a chair and back again, and how to feed himself. With the cooperation of the nurse on the ward, this becomes constant activity instead of merely a clinical exercise. Self care helps to reassure the patient that some recovery can and will occur.

The responsibility is slowly shifted from the team to the patient over a period of weeks or months. As the other modalities of physical medicine increase the patient's motor ability, as the affected hand shows functional return, the attempted activities become more difficult such as sewing, weaving, and carving. This integrated approach of physical therapy, occupational therapy, and speech therapy has a direct effect upon the rapidity and degree of functional rehabilitation made by the patient.

A word about transcerebral diathermy.[2] This was first reported by S. Hadden and B. McGlone of the University of Pennsylvania's School of Medicine and myself. The good results obtained from diathermy to other parts of the body prompted us to study its effect upon the brain. Improved circulation is an asset in any organ where the circulation is sluggish or dormant. We began these observations in the hope of bringing about a more effective circulation in the area of brain involvement. We did not expect to restore function to areas of the brain where disintegration was complete; but by improved circulation we thought we might lessen the symptoms which may result from the area of reaction surrounding the affected brain tissue. By no conception can measures to the affected or paralyzed parts alter the existing brain lesion.

The following observations were noted clinically:

1. *Sleep*—The patients said they were able to sleep through the night without medication.
2. *Tremors*—Much less, with better control of extremities.
3. *Spasticity*—Reduced, better relaxation.
4. *Circulation*—Feeling of warmth to the affected extremities.
5. *Mental Attitude*—From a morose, depressed feeling to one of cheerfulness and hope.
6. *Strength and Coordination*—Marked improvement—The patient would ambulate earlier.

7. *Speech*—Improvement in articulation. One subject had complete motor aphasia; and after the fourth treatment, this patient began to utter a few words.

8. *Nervousness*—Members of the family noted that patients were less "nervous," not so tense.

9. *Numbness*—This disappeared in the affected extremities after 4 to 6 treatments.

10. *Convulsions*—One patient who used to have 3 or 4 epileptic seizures a week found he was suffering only 2 a month—and the phenobarbital and diphenyl hydantoin could be discontinued.

We do not have reports from other clinics and do not know if transcerebral diathermy was instituted. If failures have occurred, we must consider the technic used, the type of electrodes, and also when this treatment began after the stroke.

The following two cases of hemiplegia illustrate several of the points already discussed and may remind the reader of similar cases with which he has come into contact. One was handled as prescribed above; the other was treated quite differently. The degree of rehabilitation is noted in each case.

Case 1

A 46-year-old woman was admitted to the hospital with a rightsided hemiplegia and difficulty in speech.

She had been a known hypertensive for five years and was being treated for that period of time. Otherwise her past medical history was uneventful. The patient had a three-and-a-half-year old child delivered by cesarean section.

On admission, she was disoriented, confused, dysarthric, and aphasic. Positive findings included: flushing, restlessness, drooping of mouth to the left, bilateral venous neck distension, blood pressure 206/120, weakness of right upper extremity, hyperactive reflexes, and a questionable right Babinski. All laboratory studies on admission were within normal limits. The electrocardiogram suggested some myocardial dysfunction.

The patient was placed on antihypertensive therapy and tranquilizing drugs, as well as on barbiturates. Three days after the acute attack, bedside physical medicine was instituted. After one week the patient was seen once a day in the physical medicine clinic, and intensive rehabilitation work was initiated including active and passive motion, weight bearing and walking, electric stimulation to the affected arm and leg, occupational therapy for activities of daily living and speech therapy. New modalities and changes were instituted as improvement was made, and the patient was seen twice a day in the physical medicine clinic. The progression of changes in one field, for example, was: walking between bars; walking with one bar; walking with a cane; walking without support.

Some 7½ weeks after the acute episode, she was discharged to continue physical medicine as an outpatient. Her gait was then within normal limits. Arm motion was good, and there was continuing improvement in finger motion and strength in her grip. She spoke in sentences, and there was marked improvement in her reading and writing ability.

The motivation of the patient was excellent due to a desire to maintain a recent marriage and return to full responsibility of a three-and-a-half year old child.

Case 2

A 58-year old man was admitted to the hospital in no acute distress, some 18 months after a cerebral vascular accident which resulted in left hemiplegia and some mental torpor. He had a family history of hypertension and cerebral vascular accidents. He himself had been treated for hypertension. During the past 1½ years he had been indulged in by his wife and children, and his improvement has been slight. He was admitted for intensive physical medicine and rehabilitation, unable to walk, and with a useless left arm.

The positive findings on admission were blood pressure 230/145; inability to walk; great emotional lability; flaccid left sided paralysis; stiffness of left arm and hand; great stiffness in left leg; enlarged heart clinically; weak pulses in left leg; edema and erythema of left leg; increased deep tendon reflexes on left side; abnormal reflexes positive on left side (clonus, Babinski, and Hoffman); muscle atrophy of left shoulder area; sensory modalities decreased-to-absent in left leg.

This patient was placed on antihypertensive and tranquilizing therapy and was seen twice a day in the physical medicine clinic. He was given active and passive exercises to the left side, electric stimulation to the left arm and leg, weight bearing, walking, speech therapy, and occupational therapy stressing the activities of daily living. The same method of changing with improvement was used.

His mental attitude and lack of motivation have kept his progress to a minimum. He must be forced and cajoled into action, and must be prodded for a response. He cries easily and always insists on not being able to do new things. At times he seems motivated, but this is merely lip service.

To date, less than seven weeks since admission, he has achieved some loosening of his left side and can walk between bars. Training with a cane is difficult due to lack of courage on the part of the patient. His reading and writing were poor and have shown little improvement in this six-week period. It is felt that his intellect was never great, but his I.Q. generally has only a minimal effect upon motivation. The patient is still being given in-patient therapy at the present time.

These cases illustrate the value of early physical medicine after the acute attack. They highlight the importance of motivation of the patient. The physician who cares for a patient who has had a cerebral vascular accident can provide the patient with the proper attitude: he can either consult with a doctor of physical medicine or train his nurses on the ward to

begin active and passive motion early. If this is followed by a good daily physical medicine program (as outlined above) and explanations to the family so that they may understand the full implications of rehabilitation, the physician will see greater success in the treatment and rehabilitation of hemiplegic patients.

The therapeutic training and rehabilitation of hemiplegics treated on an out-patient basis follow a similar program as outlined above and are dependent upon early training and motivation, also. Here, however, there are added limitations. The major obstacles are: (1) reducing the number of clinic hours per week; (2) interference and misunderstanding of the family; (3) inactivity on the part of the patient at home; (4) emotional stress in daily living; (5) frustrations relative to the handicap.

Summary

A program of Physical Medicine and Rehabilitation has been presented which is in actual use and which has served to improve both the prognosis and the speed of improvement in patients following a stroke.[3]

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University of Pennsylvania School of Medicine

Does The Patient Save By Generic Name Prescribing?

Not always, says an official of Smith, Kline and French in an appeal to the public. A cheaply made drug, they suggest, may show such poor absorption or may lose so much potency on the shelf that it may cost more to buy an effective quantity of the lower-priced drug than a soundly made tradenamed pharmaceutical. In its report to the public, SK&F writes that

. . . a drug usually has three names. The first describes its chemical structure. As a rule, this chemical name is too long for everyday use, so a simpler 'generic' name is coined. And finally, there is the trademark name under which a company markets the product.

As an example, the chemical name of a well-known stimulant is *d*-1-phenyl-2-aminopropane sulfate. Its generic name is dextroamphetamine sulfate. But the product in medicinal form is marketed by SK&F under the trademark name 'Dexedrine.'

A physician may prescribe 'Dexedrine' by its trademark name or he may write 'dextroamphetamine sulfate, SK&F'—in either case, the pharmacist knows that he is to fill the prescription with SK&F's product. Or the doctor may simply write 'dextroamphetamine sulfate tablets.' This is called 'generic prescribing.' The pharmacist may fill this prescription with dextroamphetamine sulfate tablets made by *any* manufacturer.

Proponents of *generic-name drugs* contend that pharmacists should fill prescriptions with the cheapest product. Since generic-name drug products are usually cheaper, they argue that prescribing by generic name would save money. Underlying their argument is the assumption that generic and trademark drug products are identical in all respects except price.

However, substandard products often find their way to the market and these are almost always generic drug products. If your doctor doesn't prescribe a specific product by trademark or indicate the manufacturer's name, he can't be sure who made the drug nor can he be sure of its quality and ingredients. Consequently, over 90 per cent of all prescriptions written today specify trademark products. The manufacturers of trademark products stake their reputation on the quality of their medicines.

Reactions to oral penicillin can be delayed—and can be fatal.

Anaphylactoid Reaction to Oral Penicillin

Report of Two Cases

Thomas M. Kain, Jr., M.D./Camden

Anaphylactoid reactions to parenteral penicillin are now occurring with increasing frequency; sometimes, indeed, with fatal outcome.[1] With the further use of oral penicillin, such reactions will become more frequent, particularly with the increasing popularity of oral penicillin in the prevention and treatment of rheumatic fever. The following two cases illustrate rather severe reactions to such therapy.

Case #1: A 28 year old intern received 200,000 units of penicillin G tablets, four times a day for four days. This was administered prophylactically due to an outbreak of scarlet fever in the hospital ward. He was one of thirty individuals who were treated with no untoward reactions. Four days after the last dose of penicillin, he noticed generalized itching. On the fifth day he awakened with small, hard, red, painful lumps on the soles of the feet. Within four hours his feet became increasingly tender and began to swell. He received diphenhydramine hydrochloride intramuscularly and orally. Shortly after this, while attending a conference, he developed sudden weakness, broke out in a profuse cold sweat, and exhibited respiratory distress. At this point, his blood pressure was 60/0 and he was cold and clammy. He was given 0.3 cubic centimeters of epinephrine intramuscularly and then admitted to the hospital.

He had taken penicillin previously without untoward effects. There was a history of alopecia areata while in medical school. A paternal uncle suffered exfolliative dermatitis from penicillin therapy. He now had a normal hemoglobin and hematocrit. White blood cell count was 45,000 with 72 per cent neutrophiles. Total eosinophile count was 121 per cubic millimeter. Electrocardiogram revealed sinus tachycardia with slight S-T segment elevation.

On the day of admission, he developed a generalized urticarial rash and complained of rectal tenesmus. He was given 40 units of aqueous ACTH intravenously, with improvement. On the second hospital day he complained of severe pain on swallowing. Largyngoscopy showed generalized erythema of the naso-pharynx. Intravenous ACTH was continued for three days with definite improvement in all his symptoms. One week following admission he was discharged with antihistamine therapy. Two days later, he had a return of the urticaria and dysphagia. He received prednisone, 5 milligrams orally, three times a day with complete relief of symptoms. Three weeks after admission, he was completely free of problems.

Case #2: A 30 year old woman took one tablet of penicillin for upper abdominal pain. She immediately collapsed, saying that her throat was "on fire." Her upper lip was swollen. One month prior to this, she had been treated with penicillin for an upper respiratory infection and developed generalized pruritis but no rash, and again felt the sensation of warmth. She had had five pregnancies. At the age of 21, she had had pneumonia. Remaining past history was negative for any significant illnesses.

She was a thin female, alert and in no acute distress. There was moderate edema of both eyelids and slight conjunctival injection. Her throat was moderately inflammed with enlarged tonsils but no exudate. Lungs showed slight inspiratory wheezes, particularly of the right. There was a sinus tachycardia. No murmurs were audible. There was no cardiac enlargement and blood pressure was 100/70. Chest x-ray was not remarkable. The abdomen was negative for masses, tenderness, or organ enlargement. Rectal examination revealed tenderness of the cervix. Adnexa were negative.

She was treated immediately with bed rest, intravenous hydrocortisone succinate ester, 100 milligrams, every twelve hours, intravenous glucose in water and epinephrine, 0.3 cubic centimeter every six hours. In two days, the hydrocortisone succinate ester was reduced to 100 milligrams, once a day and eventually changed to triamcinolone acetate, milligrams 4, twice a day. The steroid therapy was gradually tapered off and she was discharged from the hospital in nine days, completely recovered, with no return of symptoms.

Bralow and Girsh[2] report massive gastrointestinal hemorrhage following urticaria of the gastric mucosa due to oral penicillin anaphylaxis. Smith[3] estimates the death rate in the United States as about 1000 people a year due to anaphylactic reaction to pencillin. Delayed

urticarial or serum sickness types of reactions are rarely fatal. Maganzini[1] reported that the mortality of parenteral injections may be as high as 30 per cent. Martin[4] cited a case of reaction to oral penicillin.

These two cases are presented because of the value of history in relation to possible reactions to penicillin therapy whether by parenteral or oral route. The first patient had a family history of reaction to penicillin. In the second, there was a previous mild reaction to penicillin therapy, in the form of edema and occasional urticaria. Both patients had severe and profound vasomotor collapse with sweating and hypotension. It is important to remember that oral penicillin reactions may occur immediately or be delayed as illustrated by these two cases. It is recommended that a careful history into the allergic background of patients be obtained when penicillin therapy is being considered.

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403 Cooper Street

Early Academy Meetings

The Academy of Medicine announces the following programs for the next few weeks.

On Thursday, *January 20,* at 7:30 P.M., the Section on Radiology will meet in the Amphitheater of the Newark City Hospital at Bergen Street in Newark. There will be a film reading session and a report on radioisotope scanning.

The Eye Division of the Academy announces a meeting on *January 20* at 4:00 P.M., which will be held at the Eye and Ear Infirmary on Central Avenue and Plane Street in Newark. This will be devoted to a discussion of corneal edema led by Dr. Jorge W. Buxton of the New York Infirmary.

The State Health Department joins the Academy in sponsoring a meeting at the Warren Hospital in Phillipsburg on Friday noon, *January 28.* This luncheon session will include a symposium on arteriosclerosis and cardiac resuscitation.

The State Health Department is co-sponsoring a symposium on "Strokes" at the Englewood Hospital, starting at 8:30 A.M., on *February 3.*

The Section on Urology invites you to a dinner meeting at 7:00 P.M., *February 3,* at the Essex House in Newark, where the evening will be devoted to the role of the x-ray in urology diagnoses.

When your patient has an abdominal mass, you worry about all kinds of possibilities. Ever think that it could be a bezoar?

Review Of Gastric Bezoars

Report of a Case of Massive Gastric Trichobezoar*

Sang Chong Park, M.D.
James S. Todd, M.D. / **Ridgewood**

Foreign bodies in the stomach are not rare, but their importance and medical interest persist. No one physician will encounter many in his practice. Yet, gastric foreign bodies do occur with some frequency, and every specialty may expect to see its share. The purpose of this paper is to report a massive trichobezoar in a ten-year-old girl and to review the recent literature on the subject.

A 10-year-old girl was admitted to Bergen Pines County Hospital because of an asymptomatic epigastric mass noted on routine examination. She had no complaints. There were no episodes of gastrointestinal trouble or particular general symptoms. No history of pica or other abnormal eating habits could be elicited.

Past history revealed only the usual childhood diseases, and an examination a year before was reported as normal.

On admission, we found a moderately well developed, well nourished long blond haired girl, appearing in good health. She was somewhat shy, but mentally alert and quite inquisitive in nature. Physical findings (including vital signs) were normal except for the abdomen where a huge mass was felt. There was, however, neither distension nor rigidity. The mass was elongate, smooth, regular in outline, hard in consistency, and movable. It was not tender. The lower margin of the mass extended to the umbilical level. No other organs or masses were palpable. Laboratory determinations were entirely within normal limits.

Radiographically, the heart and lungs were normal. Plain films of the abdomen gave the impression of a soft tissue density in the mid-abdomen. The liver, renal, and splenic shadows appeared normal. An intravenous pyelogram demonstrated prompt function with normal position and appearance of the kidneys. A barium study of the upper gastrointestinal tract showed the stomach to be enlarged and filled with an irregular mass around which the barium passed close to the stomach wall without an evidence of obstruction or ulceration. The duodenum and upper jejunum were normal. (Figure 1).

The patient was explored with the pre-operative diagnosis of a gastric bezoar, probably derived of hair. At surgery, the stomach filled the entire upper abdomen and contained a J shaped mass which moved independently within its lumen. No other abnormalities were noted within the peritoneal cavity. A long longitudinal gastrotomy incision was made from which was then delivered a hair ball shaped like a cast of the stomach. (Figure 2). The gastrostomy and abdomen were closed without drainage, and her post-operative course was smooth in all respects.

Pathologically, the specimen was composed of hair, small amounts of food particles, and retained gastric secretions. It weighed 713 grams and measured 21 by 7 centimeters. It was J shaped, conforming to the outline of the stomach. (Figure 3).



FIGURE 1

Roentgenographic appearance of bezoar on G-I series.

The etymology of the word bezoar is not positively known. It is believed that it originated from the Arabic word "bedsehr" or the Persian word "padzahr," meaning counterpoison or antidote. Since the 12th century, animal bezoars have been used as antidotes to poisons, and as remedies for such serious maladies as plague, leprosy, epilepsy, dysentery, and other more bizarre conditions. In the 20th century, they have been used under the curious name of "mad stones" to counteract poisons and to prevent disease. The first clinical case[1] of

* At the time this paper was prepared, Dr. Park was an intern at Bergen Pines, from which hospital this study comes. Dr. Todd is the director of Surgical Education there.



FIGURE 2
Bezoar as it appeared at operative removal.

bezoar was reported in 1779; and since that time, bezoars have assumed the position of a medical curiosity of some importance, especially among children and emotionally disturbed individuals.

Traditionally, bezoars have been classified in four groups: (1) trichobezoars consisting of hair; (2) phytobezoars composed of vegetable matter; (3) trichophytobezoars, a mixture of these two: and (4) concretions, such

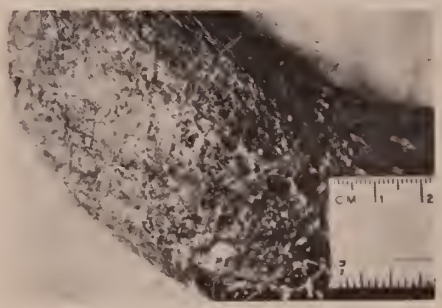


FIGURE 3
Trichobezoar removed at operation (close-up view).

as tar, shellac, sand, resin, gums, and the like. Recent writers, however, have suggested a different nomenclature in which the bezoar would always be described by its specific components. For example, *lactobezoar* for concretion of powder milk; *lignibezoar* for wood splinters; *starch gastrolith* for concretion of starch; *mucus bezoar, silico-bezoar, schellac bezoar,* and *diosopytobezoar* for persimmon instead of the generic phytobezoar which is usually used to describe bezoars of diverse composition. Bezoars may be derived from any indigestible material or from overwhelming amounts of poorly digested substances.

Bezoars may appear in both sexes and at any age, even in premature or in newborn infants. The most extensive study[3] of bezoars, analyzing 311 cases, showed an age range of 18 months to 52 years. By far the great majority (about 90 per cent) occurred in young females.[4] Eighty per cent of all trichobezoars were in patients less than 30 years of age. Phytobezoars,[5] in contrast, were much more common in young or middle-aged males. although they did occur in women.

In a large series, 55 per cent of bezoars were trichobezoars; 40 per cent were phytobezoars; and 5 per cent were concretions.

The formation of bezoars depends upon the ingested material. The process is often related to mental disturbances leading to eating of nondigestible material, or to pica in children, the undigested residue of foodstuffs, and the

accidental ingestion of occupational materials, such as sometimes seen in brush makers or wool spinners. The mechanism of bezoar formation presumably depends upon the characteristics of their components. For instance, in the trichobezoar some of the swallowed hair passes on into the intestine; some remains in the stomach to act as a nucleus over which more and more hair will be deposited until the entire stomach is filled. Sometimes, long hairs may pass through the pylorus, and an intestinal bezoar may be formed.[6] Trapping of other foodstuffs and moisture contribute to the sometimes large size of the bezoar, since when dehydrated, the weight of the mass may drop by 90 per cent. The largest trichobezoar reported was 6.5 pounds removed by Davies[7] in 1921. In the phytobezoars, often the seeds and gels of the fruits form a coagulum in which other materials are caught contributing to the formation of a foreign body which will not pass. Concretions of great variety have been described. These are usually of industrial origin. Occasionally concretions have been iatrogenically caused by the long term administration of such things as Kolantyl® gel for gastric ulcer or bismuth. Polybezoars may contain the most surprising items. Holmes[2] reported a polybezoar weighing 2850 grams removed from the stomach of a mentally retarded woman. It was composed of 263 safety pins, 23 stones, 17 fragments of bath towels, 16 metal snaps, and assorted other items. Chalk and Foucar[8] in 1929 removed from a mentally ill patient a polybezoar composed of 2533 pieces of metal and glass. This was the greatest number of foreign bodies on record.

Depending upon the size, composition, and location in the gastrointestinal tract, the symptoms of bezoars are variable. In general, there will be malaise, weight loss, vague abdominal pain, anorexia, sometimes vomiting, diarrhea, or constipation. Usually in the smaller bezoars [or sometimes even in the larger bezoars] there may be no symptoms at all, or perhaps only occult blood in the stool. The larger bezoars may present as palpable masses unaccompanied by systemic symptoms. Mild secondary anemia and leukocytosis are common. Gastric trichobezoars show low gastric acidity with mild symptoms, while the phytobezoars are accompanied by normal or high acidity and show a rather fulminating course without regard to size. Occasionally, bits of the bezoar may be vomited or appear in the stool. Rarely, gastric bezoar will give symptoms similar to stomach cancer.[9] Intestinal obstruction may occur: It is usually a late manifestation. Perforation of the gastrointestinal tract by a bezoar is uncommon, but obstruction may lead to proximal pressure perforation. Patients in whom bezoars are found not infrequently show psychiatric aberrations which account for the ingestion of the strange material. Still, bezoars in otherwise normal people are not rare.

The most common complications of bezoars are gastrointestinal ulceration with minimal bleeding and intestinal obstruction. DeBakey[3] found gastroduodenal ulceration in 24 per cent and obstruction in 27 per cent of cases he reviewed. In persimmon bezoars, the incidence of ulceration interestingly enough climbs to 71 per cent. Obstruction may be due to the mass itself, or secondary to an intussusception[10] caused by the bezoar. Distal ileal obstruction may be produced by a bezoar. One case[11] of intestinal biliary fistula has been reported. Although there is no clear-cut relationship, there has been reported[12] a case of a 25-year-old woman with a gastric trichobezoar having multiple polyps and malignant degeneration of one of them.

In general, the history will reveal evidences of mental disturbance or retardation and the ingestion of some bizarre or known indigestible material. Physical examination may be negative but more commonly there will be a palpable movable mass which does not conform to the criteria for a tumor. X-ray and fluoroscopic examinations (using contrast material) are usually sufficient to confirm the nature of the condition. It is rarely necessary to resort to gastroscopy for definitive diagnosis. Barium studies usually show an intraluminal mass around which the barium will pass, leaving an irregular filling defect. By its serpiginous outline, this will be sufficient for diagnosis.

Occasionally (particularly with large masses in children) the differential diagnosis will have to include consideration of the more common causes of masses in the abdomen, such as neuroblastoma or Wilm's tumors.

The preferred treatment of bezoars is surgical removal. Rarely, polybezoars of industrial or iatrogenic origin may be "dissolved" by chemical means. It is unusual for the organ containing the bezoar to be otherwise abnormal, except for secondary ulceration. In general, an open removal and closure without drainage is all that is required. The patients may be expected to do well. The untreated mortality runs about 75 per cent according to Vermilya.[5] Because of the often depleted condition of patients with bezoars (particularly those with emotional aberrations) the operative mortality still runs about 4 per cent as reported by Hurwitz.[4] Death when it does occur is usually due to a major complication of the bezoar itself, such as obstruction, bleeding, or very rarely, perforation.

Recurrent bezoars are not uncommon in mentally disturbed or retarded patients. In these instances an additional aspect of therapy is the determination of the dynamics of the bizarre eating habits. It will often be possible for the psychiatrist to correct this aberration; but in some patients, only careful observation will prevent recurrence. For those patients, otherwise normal, in whom the bezoar formed as a dietary accident, explanation of the factors involved suffices.

Summary

A trichobezoar in a 10-year-old girl has been presented with a brief review of the pertinent literature. While uncommon, these lesions should be considered in the differential diagnosis of abdominal masses, particularly in retarded or mentally disturbed patients. The definitive diagnosis is made by roentgenography. The benign nature of bezoars makes them satisfying to treat. Surgical intervention is indicated whenever the diagnosis is made.

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130 Prospect Street (Dr. Todd)

Morris County Medical Society Exhibit and Open House

During the month of September, in conjunction with the 250th anniversary of Morristown, the Morris County Medical Society held an "open house" with displays of historical material owned by member physicians and information regarding the public service role of the organization.

Seymour F. Kuvin, M.D., Chairman of the Public Relations Committee, arranged this highly successful program. The Morris County Component Medical Society is one of the first component members of The Medical Society of New Jersey.

Here is an interesting observation on the overlap between pediatrics, psychiatry, and public health.

Community Psychiatry And Pediatrics*

Dominick Calobrisi, M.D., Y. S. Kim, M.D. and William E. Ganss, M.D. / **Plainfield**

With the decrease of the stigma and the increasing awareness of the crippling qualities of mental illness, psychiatry has moved out of the isolated asylum into communities where psychiatric care is provided both by private practitioners and community clinics. As a result of this shift, psychiatric services are now available to most people in major geographic areas of the United States and to all persons living in New Jersey. However, working in a psychiatric clinic, the doctor becomes aware that the majority of the patients using its services have definite middle class orientations, or at least aspire to be part of the social and economic group which we usually call "the middle class." This is not to say that clinics do not reach many patients from under-privileged areas and from other deprived social and economic groups.

A unique opportunity recently presented itself for the Union County Psychiatric Clinic to offer (on a trial basis) psychiatric services to persons who ordinarily would not seek them. This is done in connection with our training program in child psychiatry and in cooperation with the training program of the Department of Pediatrics of the Muhlenberg General Hospital in Plainfield, N.J. A Fellow in Child Psychiatry has been assigned to one of the pediatric clinics in Muhlenberg General Hospital and another is affiliated with one of the "well baby stations" administered by the Visiting Nurse Association and located in a housing project built in an underprivileged area in a lower income Negro neighborhood.

The present paper will cover briefly only that part of the program which functions in relationship to the "baby station." The objectives of such a station are to provide periodic physical examinations of children, to instruct the parents in the feeding of children, to instruct parents about hygiene and physical care of the child, to protect against communicable diseases by immunization, and to instruct parents on the process of normal growth and development. The "child health care conference policy" has been set up, not only to prevent physical illness and to follow the physical growth and development of the child, but also to follow the emotional growth and to evaluate any difficulty arising in the parent-child relationship, with the goal of ultimately preventing mental illness by intervening in such a manner as to promote the mental health of the family.

The psychiatric resident has focused mainly on the mental health of the family and the prevention of mental illness in both children and parents. Other significant goals have included teaching better interview technics to the pediatric residents, helping the staff nurses and pediatric residents in recognizing emotional problems, and ultimately, helping them to intervene constructively before the pathologic process becomes fixed or poses a serious disability. Of course, the child psychiatry resident also has the opportunity to observe a great number of normal infants and children and to study reflectively the relationships between parents and children in our subject population.

Some of the pathology that we looked for and

* From the Union County Psychiatric Clinic and the Pediatric Service of the Muhlenberg Hospital in Plainfield, N.J.

tried to prevent are: psychogenic mental retardation (pseudo-retardation), behavior disturbances, and withdrawal in children. We provide guidance to the parents of these children whenever problems are observed by the "well baby station" staff or verbalized by the parents. We refer them to the appropriate agency or clinic if more sustained treatment is indicated. Occasionally, referral to the psychiatric clinic for prolonged treatment of the child and counselling of the parents is in order.

As a result of these experiences, it appears to us that the best way to achieve our goals is to provide on-the-spot interviews with the parents—interviews that combine diagnostic and therapeutic goals. The structure of these interviews is supportive, insightful, and, at times, a merger of the two in the form of counselling or guidance sessions.

An important secondary benefit is the enhanced communication between the trainee in child psychiatry and the more traditional medical personnel. In our "well baby station," there has never been danger of our not being accepted or of not being understood by any of the members of the team. The presence of a mental health nurse on the Visiting Nurse Staff has contributed a great deal to this understanding. The pediatrician in attendance (although pressed by time and by the great number of children he must provide service for in only a few hours) is able and willing to provide counselling. The nurses who do most of the interviewing of the mothers have been influenced by the child psychiatry residents to elaborate their interviewing technics to include searching questions aimed at recognizing disturbances in mental and emotional growth. They refer to the resident in child psychiatry all the subjects who, they feel, need additional counselling or cases that require more intensive study. The morale of the "well baby station" has been enhanced by their finding problems which would otherwise have passed unobserved or for which realistic solutions could not be provided by the traditional members of the team. There have been discussions of the basic principles of child psychiatry and of child development. We have all profited by an exchange of literature of common interest and by discussions of cases in a semi-structured conference at the end of the afternoon. A case discussion has often resulted in follow-up counselling with the parents at the well baby station and by home visits during which the nurses have continued to apply the principles initiated at the clinic.

From the point of view of the child psychiatry resident, many of the community needs have been better understood through direct work with a large number of needy families. We have observed a need for integrated nursery schools to provide stimuli and experiences for young, underprivileged children, who might otherwise have become (in certain cases) socially and/or psychologically retarded. The personnel of the well baby station, the patients and the parents seem to be at an historic moment where they are ready to accept and use the knowledge coming from psychiatry.

It is interesting to note that basic instruction in infants and children diets is not as necessary as it used to be because of increased knowledge on the part of the parents themselves. Tuberculosis is not the great problem that it was only a few decades ago. Congenital and hereditary disturbances are now picked up at an earlier age and are more effectively treated. We see, in this setting, many behavior disturbances and disturbances of mental growth. Here, too, we see many untreated cases of mental retardation and speech disturbances which require planning for the future. The child psychiatrist learns a great deal about the "underprivileged mother" and her ways of raising children. The children themselves are the primary beneficiaries of this sort of program, which is a rather inexpensive but a considerable contribution to the war against mental illness and poverty.

111 East Front Street

STATE ACTIVITIES

WILLIAM L. VROOM

Half as old as the Society

In this year, 1966, The Medical Society of New Jersey celebrates its 200th anniversary—and one of our members marks his hundredth. Half as old as our Society is our beloved Bergen County colleague, Dr. William Loveridge Vroom.

He was born in Hoboken on April first, 1866. Dr. Vroom was a direct descendant of the first settlers in Niew Amsterdam: those hardy souls who seldom required a doctor even under the rugged colonial conditions in Bergen.

Following grammar and preparatory school education, he taught primary grades in a one-room schoolhouse. At that time he began to read medical journals, and his interest in medicine was born.

As was the custom in those years, Dr. Vroom's studies began with an apprenticeship to a practicing physician by assisting on rounds of house calls and in the office; and by studying the disarticulated skeleton and texts available in the doctor's office. From 1884 to 1888, he received his formal medical training at the New York University Medical School.

Soon after Dr. Vroom was graduated from medical school, he established his practice in the then small rural village of Ridgewood. Today, his shingle is still there, though at the age of 100, he is inactive.

In addition to 1888's daily rounds of a country doctor (including the delivery of well over 2,000 new citizens of New Jersey), Dr. Vroom has several "firsts" to his credit. He was the first doctor in this country to use insulin provided through the Rockefeller Foundation; he was one of the first to use diphtheria antitoxin in clinical practice; and he instituted mosquito control measures in the "home" of the mosquito at a time when most of his contemporaries thought malaria was due to the dank swamp odors. To provide the best medical care within his ability, he kept his information up-to-date with graduate courses at Johns Hopkins Hospital and at the New York Postgraduate Medical School and Hospitals.

Dr. Vroom's ever-curious, ever-ingenious mind sought out almost everything. He actually constructed a workable telephone, following the design developed by Alexander Graham Bell, but adding a couple of Vroom improvements. Then he put up the poles and strung the wires until the fledgling Telephone Company, feeling threatened by the activities of this gifted amateur, insisted on his removing the apparatus. He was the very first physician in all New Jersey to have a telephone. He must have been one of the first to have an automobile, for in 1898 he bought himself a steam-driven Locomobile which soon became a familiar (if sometimes threatening) chariot over the muddy roads of 19th century New Jersey.

Of course he had many, many friends. One of them, Woodrow Wilson by name, faced with troubles south of the border, sought a team to carry a message to Villa. That was Francisco Villa — everyone called him "Pancho"— one of Mexico's dissident generals. President Wilson named his two-man team—Paul Fuller and William Vroom—to get into the heart of Mexico and deliver the message. It was 1915, and they couldn't do it by plane.

Two years later came the war to end wars — and William Vroom, then just 50 years old, insisted on going in and going over. He became a colonel and commanded Base Hospital 49 somewhere in France.

In his long association with the village of Ridgewood, he has been more than a leading physician. He has been a member of the village Board of Trustees and later, of the Board of Health. He originated Ridgewood's

water and sewage systems. He was a founder and director of one of its leading banks. He was the County Coroner. He founded the first local hospital. When this hospital's facilities became inadequate, he was (at the age of 82) a spark-plug in organizing and building the new $2,000,000 community hospital there.

The vigor of this man has been remarkable. Not until he was 91 did his activities become somewhat limited. As recently as 10 years ago, his practice was active. Then just to get a rest, he took a month-long pack horse trip in the Rockies.

When we celebrate the 200th anniversary of our Society, a special spot in our Hall of Fame must go to this extraordinary exemplar of the best in medical practice. He earned his laurels not in the laboratory, not in doing basic research, but in the tougher arena of helping human beings. He was a counsellor, a civic leader, a student, a teacher, a physician, and lover of people and of living.

When asked why, in his advanced years, he continued to work so hard, he would quote Goethe: *Wenn man alt ist, muss man mehr thun als da man jung war.*

In this man there is so much more to count that we do not count his years.

Floyd E. Keir, M.D.

Two N.J. Doctors To Viet Nam

While many of us talk about Viet Nam, two of our colleagues are *doing* something. Dr. S. William Kalb of Newark and Dr. Francis E. Gilbertson of Red Bank are going there to render much needed medical service.

From our safe stance in the Garden State, all we can do perhaps is to salute them. They go with our best wishes for bon voyage, a dedicated service and a safe return!

Opticians' Attitude Towards S-2658

There is now before the U. S. Senate a bill identified as S-2658. This would, in its own terms, "prohibit physicians from profiting from the sale of devices." The attitude towards this proposal manifested by the Guild of Prescription Opticians has been the subject of some interest. The Guild, through its Executive Secretary, has released the following resolution which they adopted at their last convention in Chicago on November 14, 1965.

Whereas, misunderstandings have arisen in connection with the position of the Guild of Prescription Opticians regarding the dispensing of eyeglasses by physicians; and

Whereas, there have been attempts to damage the historic and close relationship between ophthalmologists and Guild opticians by misrepresentation on this issue; and

Whereas, the Guild's record is clear in its support of medical eyecare as being in the best interest of the public;

Now therefore, the Guild of Prescription Opticians of America, adopts the following restatement of its policy:

Organized medicine at the national and local level should exercise control over all practices by individual physicians which bring discredit to the profession. We will support every action which would make federal legislation unnecessary.

It is in the patient's best interest if an ophthalmologist dispenses eyeglasses in a community where adequate independent optical services are not available.

We repeat our pledge to encourage skilled opticians to provide independent optical services in these communities if requested by an eye physician.

It is in the best interest of the public and ophthalmology if licensing of opticians were obtained in all states and we solicit the active help of ophthalmology and all medicine in securing such laws.

Better lines of communication should be established between medicine and opticianry in order to pursue matters of common interest and concern in an atmosphere of mutual respect. We stand ready to work with any individuals or groups interested in making this possible.

BICENTENNIAL CELEBRATION
May 14-16, 1966
Haddon Hall, Atlantic City

Trustees' Minutes

November 14, 1965

A joint conference of the Board of Trustees with presidents of component societies was held at the Executive Offices on Sunday, November 14, 1965, at 11:30 a.m., following the third conference of county presidents — which was held earlier in the morning. A total of 22 presidents and/or presidents-elect represented 14 component societies, as follows: Atlantic, Bergen, Burlington, Camden, Essex, Hudson, Mercer, Monmouth, Morris, Ocean, Passaic, Sussex, Union, and Warren.

Dr. Dorothy Klughaupt, First Vice-President of Passaic County, was unanimously elected chairman for the year — to succeed Dr. Francis A. Pflum of Monmouth County. Dr. Klughaupt reported the group's discussion to the Board. The significant items were:

Future Meetings . . . It was the unanimous opinion that the meetings continue to be most profitable, and the next one should be held in March 1966.

Bicentennial Dinner . . . The group received for transmission to their component societies the followng suggestion from the Board:

those component societies which would like to invite their local (state) legislators to be their guests at the bicentennial dinner in Atlantic City on May 17, 1966, should be free so to do.

MSP Benefits to Non-Participating Physicians . . . Two members expressed their disagreement with the MSP Non-Assignment Policy re Non-Participating Physicians. Members were urged to look for Legal Counsel's article on this topic in the December issue of THE JOURNAL.

JEMPAC Activities . . . With the permission of the chair, Mr. William Watson, AMPAC field man, addressed the morning session. Component societies were urged to take under advisement county medical society option JEMPAC billing.

Congress of County Medical Societies . . . Through the President of the Bergen County Medical Society the group was informed of the existence and purpose of the Congress of County Medical Societies. Supporting informational data was supplied to the presidents of component societies for discussion at local level.

Purpose of Meeting . . . The Board reaffirmed for those present that the purpose of these meetings was to give component society presidents and/or presidents-elect a forum for free and open discussion with one another and with members of the Board, to encourage improved mutual understanding of problems of MSNJ as well as those of each component society. As an informal discussion group, county officers have no authority to act as a unit — either for themselves or for their component societies.

Communicable Diseases . . . Members of different component societies reported on the confusion at local level concerning the mandatory reporting of communicable diseases. All present agreed that it would be helpful to evolve standardized forms for overall reporting of communicable diseases. County presidents were urged to discuss this matter locally and to forward any suggestions to MSNJ for consideration by the appropriate committee at state level.

Attention was called to the fact that the New Jersey State Sanitary Code has undergone extensive revision in the past year. Under this revision, certain diseases were deleted from the heretofore list of reportable diseases, including some suggested by MSNJ.

Copies of the current version of the Sanitary Code will be sent to presidents of component societies for their information and guidance.

In this same connection, component societies were urged to encourage members to take more interest in the activities of local boards of health and, where possible, to seek the appointment of physicians to these boards.

Regional Planning Councils . . . The group's

attention was called to local regional planning councils being established throughout the state. Component societies were urged to become acquainted with these councils in their area and to become participating members. A breakdown of the state by regional planning councils will be sent to the presidents of component societies.

November 21, 1965

A regular meeting of the Board of Trustees was held on Sunday, November 21, 1965, at the Executive Offices. For the fuller information of our members, more detailed minutes are on file with the secretary of each component society. A summary of the significant actions follows:

Board of Nursing . . . Appointed Dr. Jesse McCall of Newton as official representative of MSNJ to serve on a committee of the New Jersey Board of Nursing to develop a master plan for nursing education in New Jersey.

Commission for the Blind . . . Appointed Dr. Ralph E. Siegel of Perth Amboy as official representative of MSNJ to attend a meeting of the State Commission for the Blind, to organize a central planning committee for the proposed "Amblyopia Program" for pre-school children.

Heart Disease, Cancer, and Stroke . . . Designated Dr. Louis F. Albright of Spring Lake, Dr. Louis K. Collins of Glassboro, Dr. Joseph R. Jehl of Clifton, and Dr. Jerome G. Kaufman of Maplewood to attend, with President John J. Bedrick, a meeting in connection with "regional cooperative efforts" authorized under the bill based upon the President's Commission on Heart Disease, Cancer, and Stroke.

Industrial Safety Board . . . Submitted the following nominations to the Governor for consideration in the appointment of one to the New Jersey State Industrial Safety Board, established under the Worker Health and Safety Act:

Dr. Rufus W. Miller, Trenton
Dr. Joseph A. Lepree, Elizabeth
Dr. Delma W. Caldwell, Linden

Medical Ethics and Professionalism . . . Authorized the following to attend a National Congress on Medical Ethics and Professionalism, to be held in Chicago under the auspices of the AMA, March 5 and 6, 1966: President, President-Elect, Chairman of Judicial Council, Legal Counsel, and Executive Director.

Academy of Medicine . . . Designated official representatives to attend meetings of the Academy of Medicine, to follow closely the desirability and/or feasibility of the Academy's applying for grants under the new Medical Library Assistance Act. This step is taken in view of the recent action of the MSNJ House of Delegates concerning a resolution dealing with the establishment of a medical library in New Jersey.

Medicare Program . . . Agreed upon the following items for reply to the Governor, in response to his request for the Society's view on the new medicare legislation, particularly with reference to Titles XVIII and XIX:

1. MSNJ has requested Medical-Surgical Plan of New Jersey to solicit designation as the official carrier for Part B of Title XVIII of Public Law 89-97 (dealing with the voluntary insurance coverage under which physicians and surgeons will be paid for their professional services).

2. MSNJ urges the Governor to assign to the Department of Institutions and Agencies the responsibility of fulfilling the function stipulated under Title XVIII and Title XIX of the Medicare Law. (Title XIX is concerned with grants to states for medical assistance programs.)

3. MSNJ declares its willingness to name a high-level advisory committee (patterned on the AMA's committee with the federal administration) to meet with representatives of state government, to help evolve satisfactory regulations and procedures for the effective implementation of the Medicare Law in New Jersey.

4. MSNJ calls attention of the Governor to the fact that it has already taken steps to improve and organize, on a uniform basis, utilization review procedures in hospitals participating in the Blue Cross-Blue Shield insurance coverages (the AID Program). This program has been endorsed and commended by the Commissioner of Banking and Insurance and constitutes a unique mechanism in the nation.

5. MSNJ offers any possible assistance in acting promptly to plan and prepare for the operation of the program (particularly with reference to Title XIX under which federal monies will become available to the states as of January 1, 1966).

Medicare Carrier . . . Re-affirmed its earlier action (September meeting) in approving and urging that MSP be designated sole carrier for the State of New Jersey in the administration of P.L. 89-97.

Agreed with Legal Counsel that, in this matter, the Board of Trustees was acting for the Society on a policy affecting the entire state. For this reason, component societies are committed to acceptance of MSP as the recommended carrier.

Liability Panel . . . Received from the Secretary for the record the following report on the special session of the House of Delegates held on November 14:

The purpose of the meeting was to discuss the Proposed Professional Liability Panel Program, in accordance with the recommendation of Reference Committee "A", as adopted by the 1965 House of Delegates.

Of the 362 accredited members of the House, 273 representatives attended the meeting—75.4 per cent.

The House, by majority voice vote, adopted the Proposed Professional Liability Panel Program.

Hospital-Nursing Home Care . . . Appointed Dr. David Eckstein of Trenton as the Society's official representative to the Advisory Committee on Hospital-Nursing Home Working Relationship sponsored by the New Jersey Hospital Association.

Emergency Room Nursing . . . Appointed Dr. Spencer T. Snedecor of Hackensack as the Society's official representative to participate in a panel-workshop on emergency room nursing sponsored by the Rutgers College of Nursing.

Future Physicians' Clubs . . . Adopted the following recommendations of the Council on Public Relations:

1. Each county is urged to have a Future Physicians' Club Committee.

2. A questionnaire will be sent to each of the component societies, to ascertain whether Future Physicians' Clubs exist under their sponsorship.

3. Counties reporting no Future Physicians' Clubs will be encouraged by the Council on Public Relations to establish them.

4. The council will organize a file of Future Physicians' Clubs by counties, and serve as a clearinghouse to assist component societies in the establishment and operation of club units.

5. A subcommittee of the council will be appointed to carry out the council's directives in this area.

Bicentennial Celebration . . . Adopted the recommendation of the Council on Public Relations that MSNJ investigate the utilization of all public informational media for the bicentennial day celebration, with special emphasis on television and/or radio coverage —or both.

Air Pollution . . . Approved the recommendation of the Air Pollution Control Committee that MSNJ co-sponsor the 2nd Conference on Air Pollution for Physicians.

Child Safety Week . . . Adopted the recommendation of the Child Health Committee that MSNJ request the Governor to proclaim the first week in April as "Child Safety Week."

Pre-school Vision Testing . . . Approved the following recommendations of the Conservation of Vision Committee concerning the proposed vision testing for pre-school children, to be conducted by cooperative efforts of MSNJ, the New Jersey State Departments of Health and of Education, and the New Jersey Commission for the Blind:

1. The visual test, the conditions for the test, and the educational program for the mothers be conducted according to criteria set forth in the pamphlet "Eye Start" formulated by the Committee on the Conservation of Vision of MSNJ, and published by the New Jersey State Department of Health.

2. That such a program be conducted in the schools, with the aid and supervision of the county medical societies and the school physicians.

3. Factors of muscle balance and coordination are not essential to an amblyopia detection program. Most essential and of paramount importance in an amblyopia detection program is to determine whether adequate vision is present in each eye.

4. Referrals of positive cases to ophthalmologists shall be made after proper evaluation by the school physician in cooperation with the conservation of vision committee of the respective county medical society.

5. The program should be instituted as a pilot study for a period of one year and the results then evaluated to determine its usefulness.

6. Accurate records of the positives and negatives and the follow-up of referral of positive cases to ophthalmologists shall be maintained and summaries thereof

forwarded to the Committee on the Conservation of Vision of The Medical Society of New Jersey.

7. The New Jersey Academy of Ophthalmology and Otolaryngology and the New Jersey Academy of Pediatrics be invited to associate with the program in an advisory or consultative capacity.

Nursing Home Care . . . Received with commendation the report of Dr. David Eckstein of Trenton on his attendance as the Society's representative at the Institute on Nursing Home Care, held in Philadelphia on October 25 to 27.

General Session on Medicare . . . Authorized the Annual Meeting chairman to invite a panel of speakers to participate in the general session on Medicare.

Bicentennial Committee . . . Appointed the following as a committee to make decisions on all "minor" matters in connection with the bicentennial celebration, as necessary, to complete arrangements: President, President-Elect, Chairman of the Board of Trustees and of the Annual Meeting Committee, and Executive Director.

Medical Education Study . . . Considered a proposal—at the request of the Academy of Medicine—for a study of continuing medical education in New Jersey as submitted by the faculty of Rutgers Medical School; concluded that the study is untimely, in view of the desirability of establishing firmly organized programs of undergraduate medical study in relation to the two medical schools in existence; agreed that, when these medical schools are firmly established and when undergraduate medical education has been satisfactorily dealt with, the Board is prepared (through a committee which it will appoint to work with the Academy of Medicine) to evolve a satisfactory procedure to improve the postgraduate medical education.

Graduate Training Program . . . Designated the following to represent MSNJ before the AMA Board of Trustees in support of the Society's protest against the "questionnaire on administrative support of graduate training programs" recently mailed to all non-federal hospitals with approved internships and residencies: President, Executive Director, and AMA Delegates Drs. Joseph P. Donnelly and Jesse McCall.

Health Care of the Aged . . . Approved a resolution for our state's AMA delegation to call upon the AMA to reconsider its decision to dissolve the national Council to Improve the Health Care of the Aged, unless the AMA is prepared to provide another agency as an adequate substitute for it.

Medical Specialists . . . Re-affirmed the position which the Society has maintained over the years and which was the subject of a resolution (#14) approved by the 1965 House of Delegates:

Resolved, that The Medical Society of New Jersey reaffirms that the practice of Pathology, Radiology, Anesthesiology, and Physical Medicine are branches of the practice of medicine and that the services of Pathologists, Radiologists, Anesthesiologists, and Physiatrists are professional services and not hospital services, and therefore fees for the services of these physicians do not belong in any benefits paid for hospital services from any source . . .

Phony Directory Solicitations

Dr. Hulett of Orange was one of many members who received an invoice for a listing in a special directory. He reminds us of this item which appeared in the September 20, 1965 JAMA, and which is here reprinted for the benefit of all our readers.

Invoice-like solicitations for listings in questionable or non-existent classified directories are once again flooding into business and professional offices, warns the National Better Business Bureau, Inc.

The solicitation forms look like genuine invoices used in connection with listings in telephone or other established directories, but a careful reading would disclose that they are merely solicitations for listings in unknown directories that may or may not be published, says the NBBB.

All of these forms state in one way or another that they are solicitations and not bills, explains the NBBB.

BICENTENNALIA

Lyndon A. Smith: Prime Mover for Mental Hospitals

Dr. Lyndon A. Smith, 44th president of The Medical Society of New Jersey, is remembered today chiefly for his efforts on behalf of the mentally ill. The stimulus of his inaugural address to the Society in 1837 led to legislation which, combined with the aggressive activities of the doughty Dorothea Dix, led to the establishment of the State Hospital at Trenton—one of the first of the modern type mental hospitals established in the United States. Psychiatric historians acknowledge the debt they owe to Lyndon Smith for the transition from callous indifference to humane care in treating the mentally ill.

Lyndon Arnold Smith was born at Haverhill, New Hampshire on November 11, 1795, son of a clergyman. After preliminary schooling, at age 14, he spent a year in the law office of Daniel Webster, in Portsmouth, before being graduated at Phillips Academy at Exeter, New Hampshire. In 1813 he entered Dartmouth College and received an A.B. degree four years later. After studying medicine in Virginia, Lyndon Smith took his M.D. degree at Dartmouth in 1823. He had the extraordinary distinction of being elected president of the Dartmouth Medical Society while in medical school.

Dr. Smith began practice at Williamstown, Massachusetts. Here he married Frances Louisa Griffin, daughter of the president of Williams College. Five years later, the Smiths moved to Newark, New Jersey. They had six children. One son was killed in action in the Civil War, another became a physician, and one was a clergyman.

Dr. Lyndon Smith served as vice president of The Medical Society of New Jersey in 1835 and was elected President in 1837. His presidential address on "Insanity," urged the need for a "State Lunatic Asylum." Responding to this, the Society named a committee to petition the Legislature. That body then appropriated $500 to survey conditions of the mentally ill in the state. Governor Pennington designated five commissioners to conduct the survey. Meeting at Newark in 1839, the Honorable Lewis Condict, M.D., was named chairman and our Dr. Smith became secretary. The Commission visited facilities for care of mental patients in New England, New York, and Pennsylvania before submitting their report to the Legislature. Daniel Haines (later twice Governor of New Jersey) was one of the commissioners who helped select the site for the hospital at Trenton. In this effort, Miss Dorothea Lynde Dix was a mighty ally in promoting support for the institution.

On March 25, 1845, the New Jersey Legislature voted unanimously to construct a mental hospital at Trenton. This was the beginning of a large family of state hospitals throughout the land. Governor Stratton encouraged this venture and signed the bill which led to the opening of a "model State Lunatic Asylum" at Trenton in 1848. The largest yew tree in New Jersey, near the main entrance to the original building, now recalls the help of Miss Dix, who brought the yew slip from Stoke Poges, England, and planted it on the hospital grounds.

Dr. Smith served as vice president of the American Medical Association in 1859, presiding over all its sessions that year due to illness of the president. He was elected an honorary member of the Rhode Island and New York State Medical Societies.

Another of Smith's philanthropic interests

concerned slavery. He was secretary of the New Jersey African Colonization Society which purchased freedom for many of them and helped promote the settlement of Liberia through a national organization.

Dr. Smith was also a "manager" of the Newark Presbyterian City Mission and of the American Bible Society. He was a lecturer at the Newark Mechanic's Institute and a Trustee of the Newark Academy. Princeton conferred an honorary degree upon him in 1842. The clock in Trinity Church steeple, Newark, was erected by funds solicited and in part donated by this useful citizen. He was a member of the Medical Board of the Mutual Benefit Life Insurance Company of Newark and a director of the Mount Pleasant Cemetery, where he was buried.

Dr. Lyndon Smith died at Newark on December 15, 1865. His life and work, in century retrospect, transcended this pilgrim's time and place.

Fred B. Rogers, M.D.

Bergen County*

The year 1688 is the first in which we hear of any doctor in what is now Bergen County: Doctor Johannes, who lived in what is now Hackensack.

The earliest physician of record in Bergen County was Dr. Van Emburgh, attested to by the record of a deed to his widow from a friend, Sara Stanford, dated December 7, 1709.

Dr. Abran Van Buskirk was a surgeon in the first militia of Bergen County.

Dr. Joseph Sackett born February 16, 1733, was one of the original charter members of The Medical Society of New Jersey, taking an active part there until 1792 when he moved to Newton, Long Island.

Dr. John Campbell, born February 13, 1770, practiced in Hackensack. It was his father, Archibald Campbell, who felt it his duty to follow Washington, retreating across New Jersey. But his family, depending upon him, counseled: "Keep neutral, remain with your family."

Dr. Joshuah Hornblower, a brother of Chief Justice Joseph C. Hornblower of the Supreme Court of New Jersey, practiced medicine in Bergen County in 1789. His practice extended over a large expanse of the country, covering Hudson County, the old Township of Hackensack, Fort Lee, and a considerable practice in Staten Island. He was appointed surgeon in the War of 1812.

In the early Colonial days—during which time the lands, now Bergen County, were being settled by colonists from Holland—there were no regularly trained physicians in the immediate territory.

The science of medicine of that time was in its infancy all over the world. Although the University of Leyden in Holland was widely known in Europe for chemistry and science, its teaching was more scholastic, religious, and intellectual rather than aimed at physical health and well-being.

At this early date, there was no school of medicine nor even a course of lectures on medical subjects in America, not until 1754, at least, when Dr. William Hunter of New Port, Rhode Island, first introduced a course of lectures for students.

In New York, a medical school was founded in connection with Kings College, 1767. Eleven degrees were conferred; the breaking out of the Revolution caused suspension of its operation.

In connection with Queens College, New Brunswick, New Jersey (now Rutgers), a medical department was established in 1792 continuing to 1816. This department, however, was located in New York City. In that

* Prepared by Floyd E. Keir, M.D.

24 year period only thirty-six medical degrees were confirmed.

In 1818, and for some years later, there was no school in New Jersey to authorize or confer the degree of Doctor of Medicine upon anyone.

A medical school was founded in connection with the Philadelphia College, in 1765, where students from the western part of New Jersey sought instruction. Only a very limited few had the advantage of medical instruction in Europe.

The medical profession in New Jersey, as well as of the other American colonies, was largely composed of those who, although without much liberal education, had spent a few months with a nearby physician, reading such books on medical subjects as could be obtained. One of these, Solomen's *Herbal,* published in England during 1699, seemed to be the standard textbook for New Jersey physicians.

Each neighborhood seemed to have some individual capable of cupping, extracting teeth, and setting broken bones in splints, thus obtaining the name of "Doctor." For maternity work female accoucheurs were employed.

The early Holland settlers of Bergen County seemed to have but little requirement for physicians' services for many years following the first settlement of this territory. The climate was particularly healthy and comparatively free from malaria.

Medicine in Bergen County received new impulse upon the organization of the Medical Association of the Province, 1766. This was the first provincial medical society of any of the colonies.

In this day and age, with cynics a dime a dozen, it is heartwarming to delve into the records of the Bergen County Medical Society and find them studded with actions that show deep concern for the welfare of the people.

As a matter of fact, concern for the public welfare is as evident today as it was yesterday. Last October, the Bergen County Medical Society established a Quality Care Committee to implement better medical care for persons of all age groups. Similarly earlier in the year a Committee on Chronic Illness and Aging was formed. An Athletic Injury Prevention Committee has been created. Our first Emergency Medical Service system was inaugurated. Thus our Society's concern for the welfare of the people has been in evidence through the years.

But to go back in time. . . . The doctors of Bergen County tried to get a District Society underway in 1818 to help the State Society curb quacks and quackery, foster educational and training opportunities for better qualified doctors, and to establish means of providing better care for the sick and the suffering.

The spirit in those days was willing and so was the flesh; but the rigors of sparsely settled Bergen County were too great. That attempt failed and a second attempt in 1836 failed because the rigors had not abated. It still took a doctor (and his wife) three days at least to make his rounds. He was expected to travel the entire wearisome circuit by horse and buggy.

So it was that on February 29, 1854 the District Medical Society was finalized with Dr. William H. Day as president, Dr. Charles Hasbrouck as secretary, and Doctors George Brown, Henry A. Hopper, and Dubois Hasbrouck to round it out.

The minutes of the meetings of the Society, except for brief periods of "ups and downs" caused primarily by the events of the Civil War, are studied with forward-looking actions demonstrating concern for the public welfare. . . .

Like the Society's campaigns — all of them successful — to bring about erection of an isolation hospital for contagious illnesses; the erection of voluntary hospitals in Hacken-

sack, Englewood, Teaneck, Ridgewood; the demolition of the hell-hole of an old jail and construction of a modern building.

Like the program that set a precedent in New Jersey for control of typhoid fever and allied diseases; the enactment of stern laws protecting the water supply and then similar action to provide adequate sewage disposal; the creation of a Bergen County Milk Commission; steps to control spread of infantile paralysis. Like the decade-long campaign, finally successful, to establish pre-school medical examinations; support for the Child Labor Laws; inauguration of vaccination of dogs against rabies; establishment of a medical relief plan in case of disasters . . .

Like the persistent petitioning of the state for full-time venereal disease control case workers; coordination of county Public Health Service Council with nursing services; creation of a cancer Control Committee; creation of a mental hygiene service; establishment of a Bergen County Blood Bank.

There are other dramatic achievements on both group and individual basis; but the pattern of public service is clear, down through the years, and everything indicates that this attitude will continue.

The One Hundredth Anniversary Meeting

This year—1966—we celebrate the bicentennial of The Medical Society of New Jersey. (No other medical organization in the western hemisphere has racked up that many years of service.) Just a century ago we held our one-hundredth anniversary session. Since Rutgers was also founded in 1766, it was appropriate that our centennial was held in the chapel of Rutgers on January 23, 1866. It was a small House of Delegates in those days —only 75 members—and 66 of them were there that winter day. The Medical Society of New Jersey used to issue licenses to practice medicine—a legal right it still has, but no longer exercises. And on January 23, 1866, six new physicians were so licensed. The annual dues were kept at $2.50 a year in spite of some complaints that this was excessive.

The President of The Medical Society of New Jersey — Abraham Coles — read an original poem: "Microcosm." The verse filled 45 pages of the transactions. It traced *homo sapiens* from the earliest fishes to modern man, and visualized the spiritual meanings of beauty and adaptability of the organs and their actions. It closes:

"I heard a voice proclaiming from the skies:-
'The dead shall live, with my dead body rise.'
Admiring angels shall the sight applaud,
Blazing with all the majesty of God."

Dr. William Pierson, of Orange, corresponding secretary, gave a historical narrative of the Society, filling 39 pages of the Transactions.

The members then went in procession to Greer's Hall for dinner, after which the following toasts were given:

1. The American Medical Association—Dr. Atkinson, Philadelphia, Secretary.
2. Our Sister Societies—Dr. Woodward of Connecticut.
3. The Medical Colleges—Dr. Hooker, Connecticut.
4. The Medical Corps of the Army and Navy—Dr. Josiah Simpson, New Jersey, and Lt. Gov. C. C. Cox of Maryland.
5. The Learned Professions—Dr. Campbell, President, Rutgers College.
6. The Colleges of our County—Dr. Traill Green, Professor of Chemistry, Lafayette College.
7. The Founders—Dr. Craig, Plainfield, the oldest Fellow present.
8. The Professional and Newspaper Press—Dr. Butler, Editor of *The Reporter,* Philadelphia.

The reports of the county societies fill 169 pages, and contain a wealth of historical information and records of health conditions. In 1866, there were 291 members of the county societies. There were 596 regular licensed physicians in the State or one to every 1300 of the population. There were also 150 "irregulars," twenty-one of them being women. The Transactions say: "Nearly all of them of the class known as the progressive bloomer kind, spiritualists, and infidels. A false religious faith and ignorance in medicine form a perfect substrate for the character of a female medical quack."

ANNOUNCEMENTS

Lymphoma of the Skin

Announcement is made of a talk on recent advances in the management of lymphoma. The essayist, Dr. J. L. Fromer, is chief of dermatology at the Lahey Clinic. This paper will be given on Tuesday, January 11 at the Hotel Suburban in East Orange at 8:00 P.M. following a Dutch-treat dinner at 6:00 P.M. The meeting is under the joint auspices of the Academy of Medicine and the New Jersey Dermatologic Society.

Recent Advances in Cardiology

The Academy of Medicine is joining with the Essex County Heart Association in presenting a symposium on homeostasis on Wednesday evening, January 26. The meeting will begin at 4:00 P.M. with a paper on hypertension and homeostasis by R. B. Hickler, M.D., Director of the Hypertension Laboratory at the Peter Bent Brigham Hospital in Boston. The second paper, scheduled for 5:00 P.M., is on edema formation and fluid homeostasis. It is by D. P. Lauler, Director of the Endocrine Laboratory at Brigham. Then at 6:00 P.M. is a hospitality hour and a reception. At 7:00 P.M. is the dinner and at 8 P.M., a panel discussion and colloquium on recent advances in cardiology. Dinner reservations (at $5) must be received by January 17. Send your check to the Essex County Heart Association at 70 East Park Street, East Orange. The meeting will be at St. Barnabas Medical Center on Old Short Hills Road in Livingston. This program was aided by a grant from Merck, Sharpe and Dohme.

Urologic Roentgenology

The place of x-ray diagnosis in urology is the theme of a meeting of the Academy of Medicine on February 3, 1966. The meeting will be held at the Essex House, Lincoln Park, Newark—and the lead-off speaker will be J. J. Seebode, Assistant Professor of Surgery at the New Jersey College of Medicine. Reception will be at 6:00 P.M., the dinner at 7:00 P.M., and scientific program at 8:30 P.M.

Philadelphia's Graduate Seminar

For the 30th year, the Philadelphia County Medical Society will hold its annual Graduate Institute. This year's program is set for March 22, 23, 24, and 25 at the Roof Garden of the Bellevue Stratford. In the spotlight this year will be cardiovascular diseases, diabetes, endocrinology, kidney disease, gastro-enterologic disorders, joint diseases, and peripheral vascular conditions. Registration fee is $10 a day or $25 for the entire program. For details, write to Dr. Donald Dupler at 2100 Spring Garden Street, Philadelphia 19130.

Survey of Salem County Teenagers

In 1956, Congress authorized the Public Health Service to collect information on the health of America's young people by special surveys. The sampling will reach Salem County, New Jersey, in February 1966. It will include examinations of the ophthalmologic, neurologic, cardiovascular, otologic, dental, and laryngologic systems. Blood chemistries, audiometries, and selected bone x-rays will be done. Parents will be told that this is not a screening test and that visits to their physicians and dentists should still be carried out. However, reports of the findings will be sent to family doctors if parents request this.

Medical Students Essay Contests

1. The AMA is offering $2000 in prizes to medical students who submit winning essays on ethics. Named in honor of the late Norman A. Welch, M.D., the contest deadline is June 1, 1966. Each entry is limited to 1500 words (about five typewritten pages, 8½" x 11" double-spaced). For more details, including suggested topics, write to Norman A. Welch Essay Contest, AMA, 535 North Dearborn Street, Chicago 60610.

2. The Association for the History of Medicine offers the coveted Osler Medal to the medical student who writes the best essay on a problem in medical history. Deadline is March 23, 1966. For details, write to Professor William K. Beatty, Department of Medical Bibliography, Northwestern University, 303 East Chicago Avenue, Chicago 60611.

Course In Oral Cancer

The highly successful courses on cancer of the oral regions will, by popular demand, be repeated this spring at the Teaneck campus of Fairleigh Dickinson University on Wednesdays: March 30, and April 6, 13, 20, and 27. This is an all-day program—9 a.m. to 5 p.m. It is co-sponsored by the State Health Department, the State Dental Society, and the University. Except for a single $5 registration fee, there is no charge. This is an intensive practical course in all aspects of the detection, diagnosis, and treatment of tumors of the oral region, salivary glands, jaw, head, neck, and pharynx. Enrollment is limited. For information, write to Dr. Ernest Baden, Department of Pathology, Fairleigh Dickinson School of Dentistry, 1000 River Road, Teaneck 07666.

Seminar on Headache

On June 25, 1966 an all-day meeting devoted entirely to headache will be held at the Conrad Hilton in Chicago. This is sponsored by the American Association for the Study of Headache. For more details, write to Dr. Seymour Diamond at 5214 North Western Avenue, Chicago 60625.

Diabetes Symposium in Neptune

Wednesday evening, January 26, is the occasion for the diabetes symposium at the Fitkin Memorial Hospital. Sponsored by the Monmouth County Medical Society in cooperation with our State Health Department, the program will review obstetrical, diabetic, pediatric, and surgical phases of diabetes. For details write to Dr. Arthur Krosnick, State Health Department, Box 1540, Trenton 08625.

February 16: The Big Sniff Program

Hold it—Wednesday afternoon, February 16—for the physicians' conference on air pollution. The colloquium starts at 1:00 p.m. and absolutely will terminate before 5:00 p.m. The meeting will be at the Clara Maass Hospital in Belleville. The theme: **Your Airside Manner**. This is sponsored by The Medical Society of New Jersey and co-sponsored by our State Health Department.

Notice To Physicians' Widows

Any physician's widow whose husband was a member of the "Widows & Orphans Society" who is in need of Blue Cross Protection for hospitalization should write to the Society at P.O. Box 95, Belleville, N.J., 07109.

New Eye Health Film Available

You are taking an unnecessary risk to your eyesight if your eyeglasses fail to provide protection against accidental injuries to your eyes. A soft rubber ball tossed by a child can shatter a lens of ordinary eyeglasses, and the fragments might penetrate the eyes.

This advice comes from the U.S. Department of Health, Education, and Welfare. We are reminded that the danger can be largely averted by wearing glasses with heat-treated glass lenses or plastic lenses, fitted in nonflammable frames. The cost is not much more than ordinary eyeglasses.

The advantages of safety glasses for reading, street wear, or protection against the sun are discussed in a new color slide series called "RX For Eye Safety." This visual unit has been developed jointly by the Public Health Service and the National Society for the Prevention of Blindness.

The new slide series is suitable for showing before school groups of at least junior high school level, service and social organizations, and religious groups, among others.

Sets may be obtained through the National Society for the Prevention of Blindness, 16 East 40th Street, New York, New York, 10016.

OBITUARIES

Dr. J. Carlisle Brown

J. Carlisle Brown was the first residency-trained obstetrician and gynecologist to practice in Atlantic County. It was estimated that he had delivered more babies than any other doctor in south Jersey history. He was a noted hunter and marksman, and was active in nearly all worthy civic enterprises in Atlantic County. He was a pioneer in our own State's Maternal Mortality Commission. He earned his M.D. at the University of Pennsylvania in 1920, and interned at the old Blockley in Philadelphia. He served a residency in gynecology and obstetrics at the New York Women's Hospital and then, in 1924, he moved to Atlantic City, where for 40 years he served the people of the South Jersey shore area. Dr. Brown was 70 years old at the time of his death.

Dr. Frazier J. Elliott

While duck hunting on October 30, Dr. Frazier J. Elliott of Hammonton was stricken with a fatal heart attack. Born in Delaware in 1906, he was a 1933 graduate of the Jefferson Medical College. Dr. Elliott was a general practitioner with special interest in dermatology. He was a police surgeon for the south Jersey barracks of our State Police and assistant dermatologist at the Cooper Hospital in Camden. Dr. Elliott saw active duty in the medical corps during World War II.

Dr. Edward J. Novak

At the untimely age of 48, Dr. Edward J. Novak died at the Perth Amboy Hospital on December 6, 1965. Dr. Novak earned his baccalaureate degree at the University of Pennsylvania and his M.D. at Hahnemann in 1943. He served in the South Pacific during World War II, rising from first lieutenant to major during his service there. On being mustered out in 1946, he entered general practice in Woodbridge and was on the staff of the Perth Amboy General Hospital. He was active in civic and church affairs in Middlesex County.

Dr. Ernest Shaw

One of New Jersey's fine old medical lives came to an end on November 20, 1965 with the passing that day of Dr. Ernest Shaw of Camden. Dr. Shaw was born in 1885 during the last week of Chester Arthur's administration as President of the United States. He received his M.D. in 1912 at the old Medical-Chirurgical College of Philadelphia and came across the river to practice in our state. For more than half a century, he served the people of Camden County as a general practitioner with special interest in ophthalmology. He was identified with the Wills Eye Hospital in Philadelphia and with most of the hospitals in the Camden area.

THE MEDICAL SOCIETY OF NEW JERSEY
BICENTENNIAL ANNIVERSARY MEETING

Saturday-Wednesday, May 14-18, 1966
Haddon Hall, Atlantic City

DAILY SCHEDULE

Friday, May 13, 1966
5:00 p.m.—Board of Trustees

Saturday, May 14, 1966
10:00 a.m.—Registration Opens
2:00 p.m.—Golden Merit Award Ceremony
followed by
Reception for Award Recipients and Their Families
4:00 p.m.—House of Delegates
followed by
Open Discussion on Medical-Surgical Plan
5:30 p.m.—Hudson County Reception for President Bedrick (by invitation only)
8:00 p.m.—Nominating Committee

Sunday, May 15, 1966
10:45 a.m.—Reference Committees
12:00 noon—Exhibits Open
2:00 p.m.—House of Delegates (election)
3:00 p.m.—General Session on Medicare
6:00 p.m.—Reception for President-Elect Jehl

Monday, May 16, 1966
9:30 a.m.—Scientific Sessions:
Clinical Pathology, Medicine, Rheumatism
Gastroenterology and Proctology, Metabolism, Surgery
Allergy, Dermatology, Pediatrics
Ophthalmology, Otolaryngology
12:30 p.m.—Special Luncheons
2:00 p.m.—Scientific Sessions:
Anesthesiology, Obstetrics and Gynecology
Cerebrovascular Diseases, Chest Diseases, General Practice
Radiology, Urology
Psychiatry and Neurology
6:00 p.m.—Reception and Dinner for Technical Exhibitors ($5.00 per person)

Bicentennial Day—Tuesday, May 17, 1966
9:30 a.m.—Scientific Program
12:30 p.m.—Luncheon
2:30 p.m.—General Assembly on History and Medicine
5:00 p.m.—Exhibits Close
5:30 p.m.—Reception by Atlantic City Convention Bureau
7:00 p.m.—Dinner-Dance ($10.00 per person)

Wednesday, May 18, 1966
10:00 a.m.—House of Delegates
1:00 p.m.—Delegates' Luncheon
2:00 p.m.—House of Delegates—continued
2:30 p.m.—Registration Closes
3:00 p.m.—Board of Trustees

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

January, 1966 VOL. XXXIX, NO. 1

DEATH FROM ASTHMA IN CHILDREN

An increase in asthma deaths at Children's Hospital of Los Angeles led to a study of factors that might be involved. These were found to include infection, aminophylline intoxication, sedation, pancreatitis, and possible cardiac failure. Care in the use of drugs is urged.

A review of deaths from asthma at the Children's Hospital of Los Angeles between 1937 and 1963 has shown that 20 of the 24 asthmatic deaths had occurred since 1952. During the same period, the overall hospital death rate declined.

At death, the patients ranged from 5 months to 14 years of age. Two children died in infancy; two died during initial asthmatic episodes, but had pathologic evidence of preexisting disease. Six deaths were sudden and unexpected; the others were more insidious. Factors contributing to death included infection, pancreatitis, aminophylline intoxication, possible cardiac failure, sedation, hypoadrenalism, and pulmonary hemorrhage.

The most frequently associated pathological finding was pneumonitis, which was present in 12 patients. Eleven had pathologic evidence of bronchopneumonia, and one had viral pneumonitis characterized by monocytic infiltration of bronchi and peribronchial tissues; one had bronchopneumonia and viral pneumonitis. There was no pathologic evidence of infection in the lungs of the other 12 patients.

Acute pancreatitis was found at autopsy in two patients, 10 and 12 years old, who had long histories of asthma.

Other factors which might have been of significance in the deaths were inadequate hydration and heavy sedation. In one case, aminophylline intoxication was a major contributing factor.

Pathological examination of the lungs of five children with severe and chronic asthma revealed surprisingly minimal changes and no evidence of destructive emphysema.

Of the six sudden unexpected deaths, all but one of the patients had been on steroid therapy. In two cases, asthmatic death appeared pathologically uncomplicated.

Statistical information pertaining to death from asthma was incomplete until relatively recently, but review of the medical literature reveals that asthma deaths among all age groups were almost unknown prior to 1930.

Mortality Trends

To determine the significance of mortality trends in the present study, comparative asthma mortality data were examined for the nation as a whole; the State of California; the County of Los Angeles, excluding the cities of Los Angeles, Long Beach, and Pasadena; and the City of Los Angeles, and the Los Angeles County General Hospital.

It was found that for all age groups, asthma mortality rates in the City of Los Angeles have tended to be higher than the national rates since 1949, but not for the County of Los Angeles or for the state.

Warren Richards, M.D., and James R. Patrick, M.D.

American Journal of Diseases of Children, July, 1965.

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for control of moderate to severe hypertension

Unique combination produces greater antihypertensive effect with lower doses

Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.



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A single product you can use even in the presence of congestive heart failure or edema

Eight out of 10 patients respond

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

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1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.



BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week — maximum reduction in seven to ten days.



Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for **EUTRON**

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

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Usually works within 3 to 4 days in osteoarthritis

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rge number of investigators have re- ed major improvement in about 75% of es. Some patients have gone into remis- . Relief of stiffness and pain may be fol- ed quickly by improved function and res- ion of other signs of inflammation. And azolidin alka is well tolerated, especially e it contains antacids and an antispas- dic to minimize gastric upset.

traindications
ma, danger of cardiac decompensation; ory or symptoms of peptic ulcer; renal, atic or cardiac damage; history of drug rgy; history of blood dyscrasia. The drug uld not be given when the patient is se- , or when other potent drugs are given currently. Large doses are contraindi- d in patients with glaucoma.

autions
ain a detailed history and a complete sical and laboratory examination, includ- ing a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

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Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects*, usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

Before prescribing, see SK&F product Prescribing Information.

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Further clinical work showed LACTINEX to be successful in the treatment of fever blisters and canker sores of herpetic origin.[4, 5, 6, 7]

No untoward side effects have been reported in 12 years of clinical use.

Literature on indications and dosage available on request.

(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.

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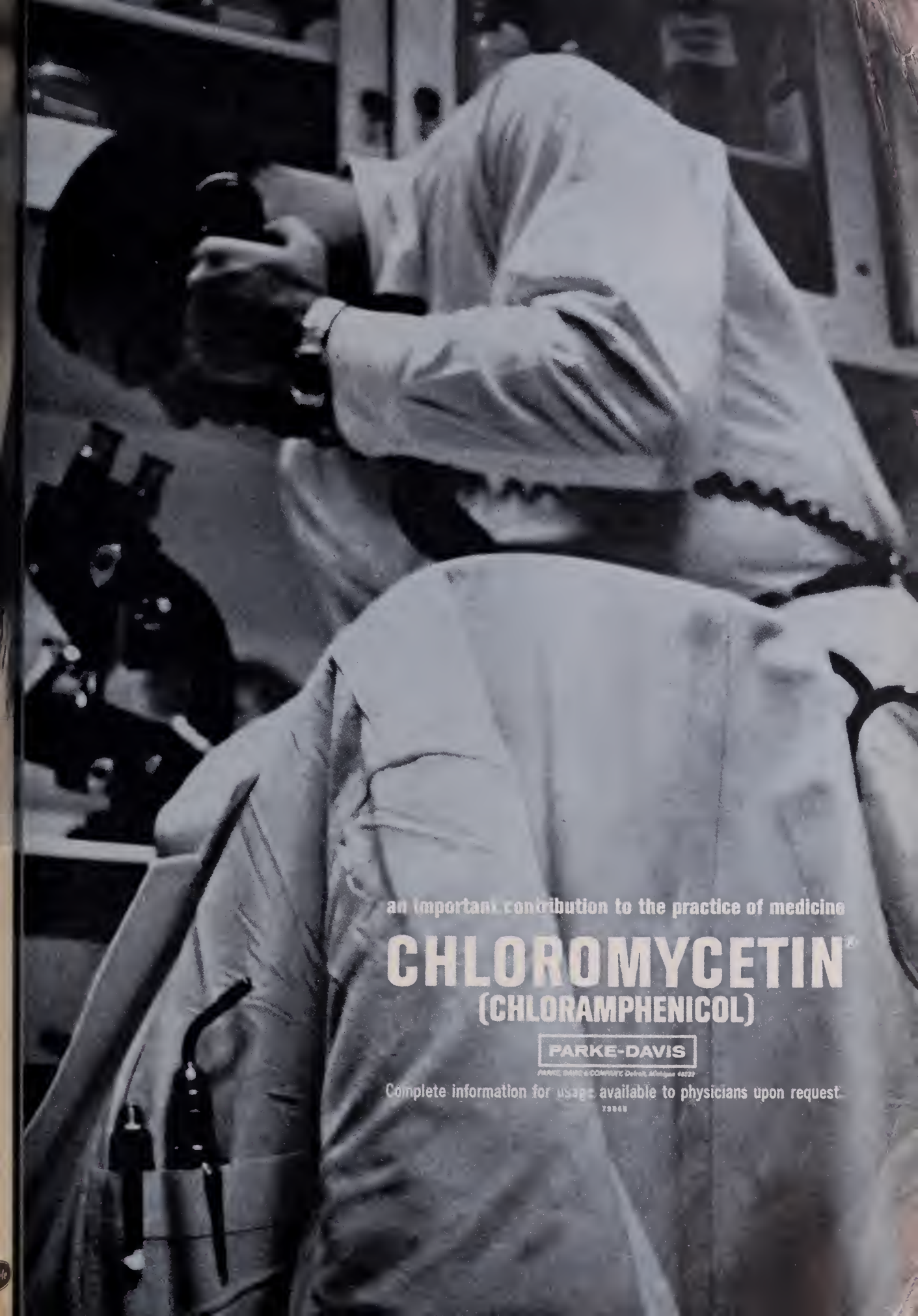
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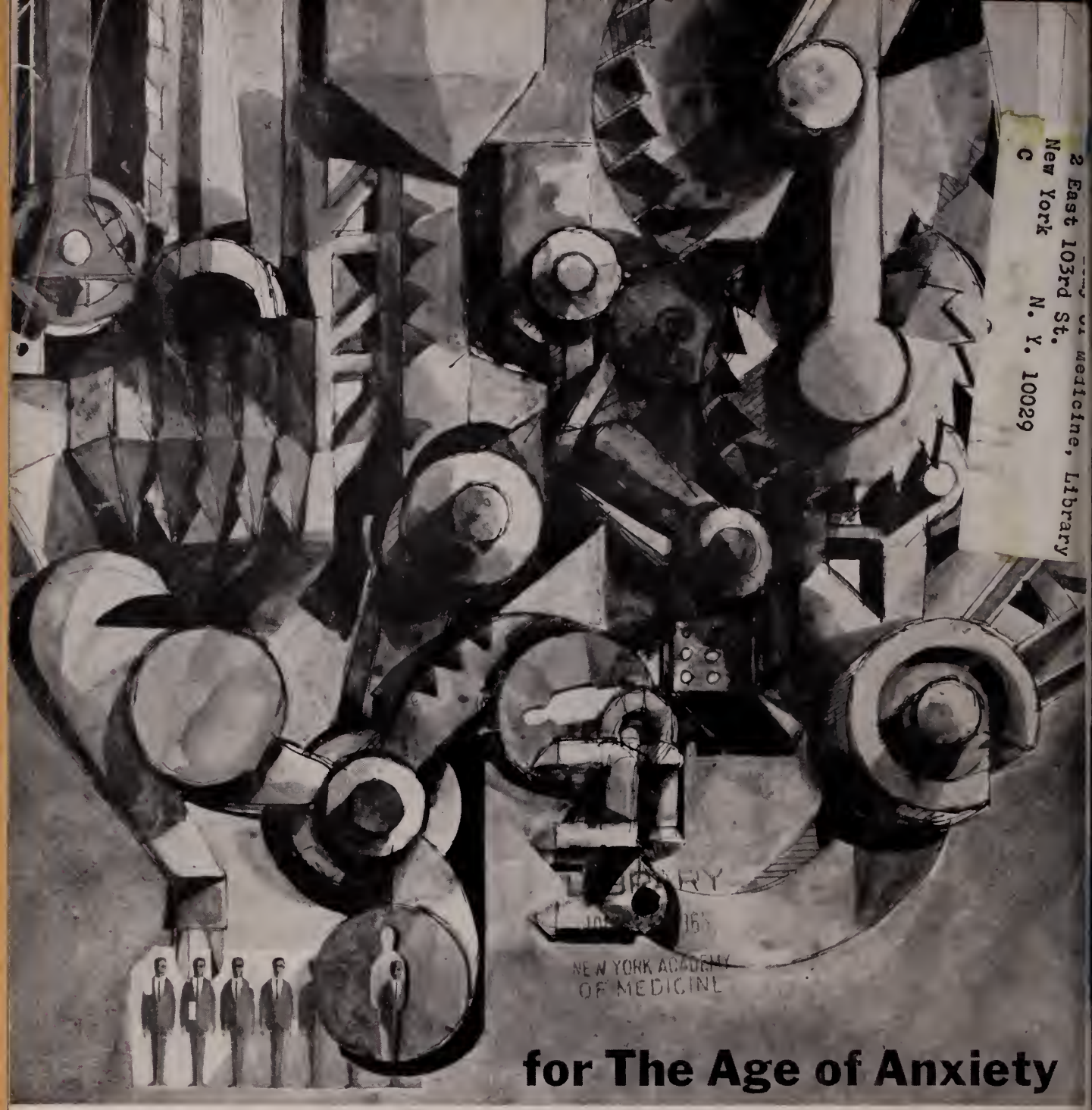
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CONTENTS • Pages 39 to 76

EDITORIALS

Rutgers and Us: Fifty Years Ago 39
Invading the Last Frontier 39
Narrative Reports vs. Questionnaires 40

ORIGINAL ARTICLES

Is Short Term Psychotherapy Enough?
Richard E. Gordon, M.D. and Katherine K. Gordon, M.A., Englewood 41
Pulmonary Edema Following Transfusion
Erwin O. Hirsch, M.D. and Antonio R. Caracta, M.D., Perth Amboy 45
Diagnosis of Minimal Brain Damage
Suzanne A. Widrow, M.D., Hanover 47
Marchiafava-Bignami Disease
Harold S. Feldman, M.D., Livingston 51
Phlegmasis Cerulea Dolens
John L. Costello, M.D., Jersey City 54
Treatment of Bleeding in Bowel Ulcer
Abraham I. Friedman, M.D., Hackensack 57
Arthrograph in Joint Diseases
Marvin Chirls, M.D., East Orange 61

STATE ACTIVITIES

Information For Contributors 46
Chairmen of Councils and Committees 53
Social Security Disability Reports 56
Trustees' Minutes: December 19, 1965 65
Methadone Is A Narcotic 67

BICENTENNALIA 68

OBITUARIES 70

ANNOUNCEMENTS 71

BOOK REVIEWS 72

RESPIRATORY DISEASE ABSTRACTS 7[illegible]

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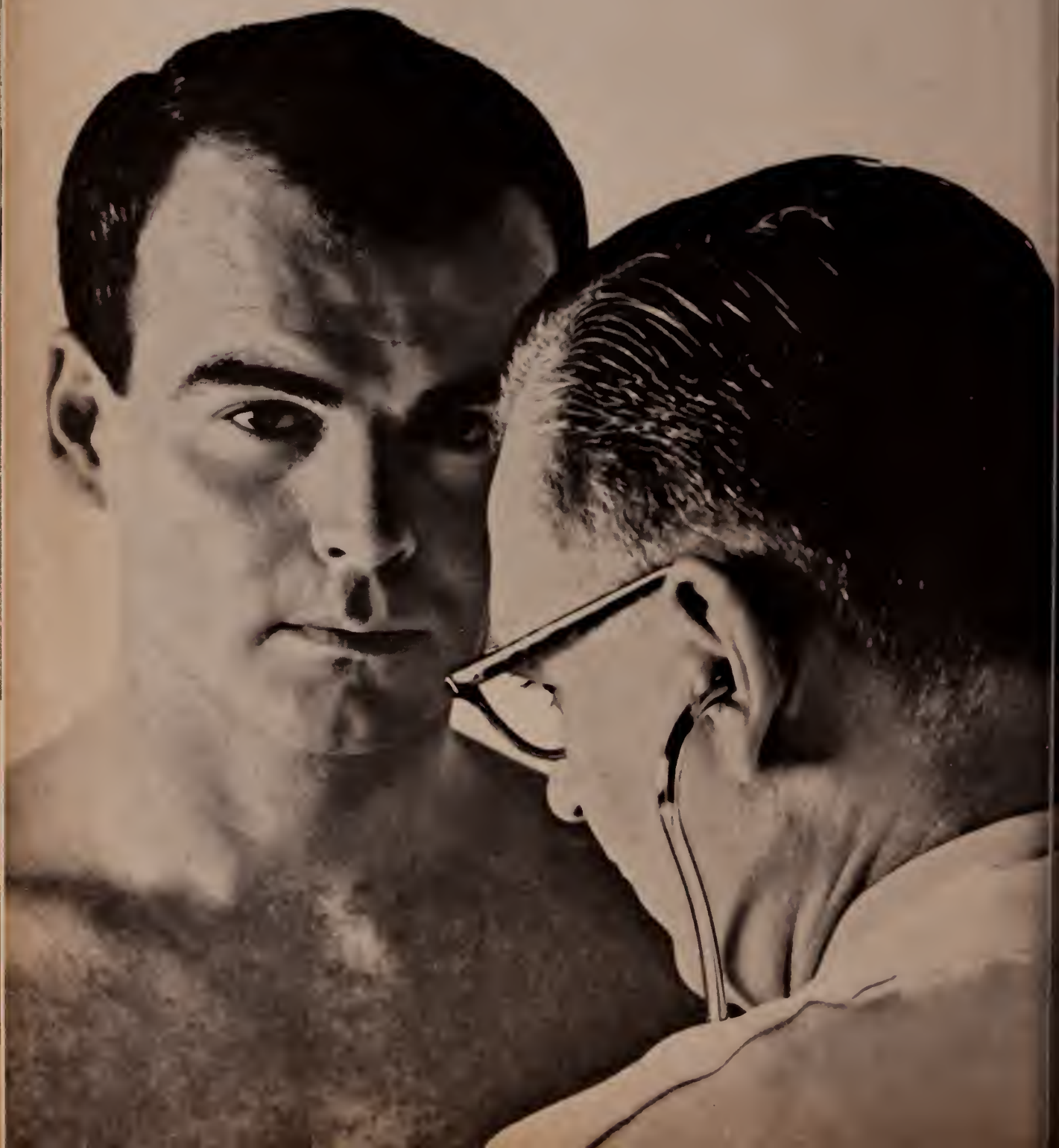
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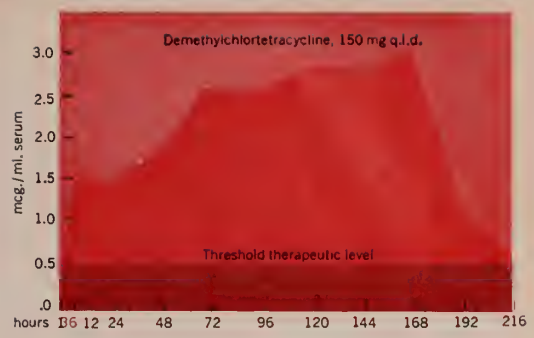




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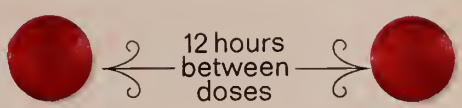
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Tablets, film coated, 300 mg and 150 mg of demethylchlortetracycline HCl.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

6785-2991

Lederle

She's on a diet.
She's discouraged.
She needs your help.

You can encourage her with DEXAMYL®
brand of dextroamphetamine sulfate and amobarbital

'Dexamyl' is the mood-lifting anorectic; it not only assures unexcelled control of appetite but also improves outlook.

Formula: Each 'Dexamyl' Spansule® (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].
Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild. *Before prescribing, see SK&F product Prescribing Information. Smith Kline & French Laboratories, Philadelphia* SK&F





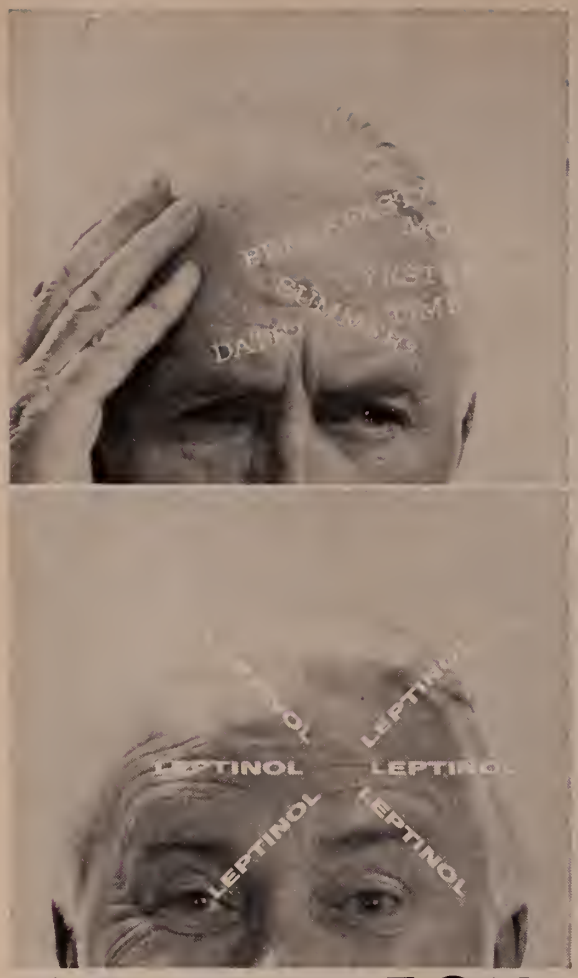
Because cerebrovascular insufficiency can be controlled

...help the older patient enjoy life with less confusion, defects in memory, dizziness, weakness, fatigue and decreased activity by maintaining the cerebral blood flow.

Administration and Dosage: Two sublingual tablets three times a day until definite improvement is achieved. This usually occurs within four weeks. Maintenance dosage of one sublingual tablet three times a day is then established to continue this improvement.
Precautions: Hydergine sublingual tablets have not been found to produce serious side effects even in doses far beyond the ones recommended. Some nasal stuffiness due to adrenergic blockade, transient nausea or gastric disturbances have been reported with high dosages.
Supplied: Hydergine Sublingual Tablets, 0.5 mg.; bottles of 100 and 1000.
Composition: Each sublingual tablet contains dihydroergocornine, dihydroergocristine, and dihydroergokryptine methanesulfonates (in equal parts), total 0.5 mg.

HYDERGINE®

SANDOZ



LEPTINOL

TRADE MARK

When elderly patients display symptoms of apathy, mental confusion, memory lapses . . . consider LEPTINOL

Leptinol is a useful medication that deters senile mental deterioration by stimulating the cerebral vasomotor and respiratory centers . . . increasing pulmonary ventilation and the supply of blood and oxygen to the brain.

Non-addicting Leptinol also is valuable in long-term treatment, since patients do not establish a tolerance.

Each LEPTINOL bi-layer tablet contains: PENTYLENETETRAZOL, 100 mg., NIACIN, 50 mg., THIAMINE HYDROCHLORIDE, 1 mg., ASCORBIC ACID, 20 mg. DOSE: one or two tablets, 3 times daily. Leptinol produces such a sense of well-being, patients should be cautioned not to exceed recommended dose which offers maximum effectiveness.

Side Effects:— overdosage may produce tremor, convulsions or respiratory paralysis.

Caution should be taken when treating patients with a low convulsive threshold.

Write for detailed literature and starter Leptinol doses.

Vale

THE VALE CHEMICAL COMPANY, INC.

Pharmaceuticals — Allentown, Pa

8A

DEPROL®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-6405

FOR THE



COMPLEX

TRY DEPROL®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

a logical first choice

FOR DEPRESSION

even when complicated by anxiety, tension, insomnia, agitation or rumination.

- **Acts rapidly.**
- **Side effects at recommended dosage infrequent, usually easily controlled.**

IMPORTANT FACTS

about

Professional Liability Coverage

Insurance that only covers claims based on the rendering of, or failure to render, professional services, or arising out of malpractice error or mistake in rendering professional services, is no longer adequate.

Our policy, approved and recommended by The Medical Society of New Jersey is broad enough to cover:

(1) the non-negligent as well as the negligent claim, such as arising out of duties as committee member in your society or hospital.

(2) The financial loss to a physician in attending trial as a defendant in protracted litigation.

(3) punitive damages for libel or slander.

This program, which was designed with The Medical Society of New Jersey and its legal counsel, and operated by a cooperative Loss Control Program, offers this broad protection, security and continuity of coverage.

Complete protection should not
be controlled by price.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

129 CLEVELAND STREET ORANGE, NEW JERSEY 07050

Joseph A. Britton, Manager ORange 3-2575

Home Office: Wakefield, Mass.



this part for diarrhea

Kaolin exerts a demulcent action along the gastrointestinal tract and a detoxifying action in the intestines to diminish irritation of the mucosa and lessen hyperperistalsis, nausea and diarrhea.

Pectin exerts its demulcent effect in the entire tract and its detoxifying action primarily in the large bowel to diminish irritation of the mucosa and help restore normal intestinal flora and function.

this part for its discomforts

Belladonna alkaloids as in Donnatal® relieve hypermotility of smooth muscle in the gastrointestinal tract to help control cramping, nausea, and painful straining. Many clinicians consider the belladonna components of Donnagel® to be medicine's most effective depressants of intestinal motility.[1,2] A preparation containing only kaolin and pectin, on the other hand, has "little or no effect on cramps simply because it does not include an agent with antispasmodic action."[3]

Donnagel® treats the whole diarrhea problem.

Available in new 4-ounce plastic bottle on your prescription or recommendation. Also available: Donnagel®-PG (with paregoric equivalent) and Donnagel® with Neomycin. See product literature before prescribing.

References: 1. Kramer, P., and Ingelfinger, F.J.: Med. Clin. N. Amer., *32*:1227, 1948. 2. Hock, C.W.: Clin. Med., *8*:1932, 1961. 3. Winfield, I.W.: Am. J. Gastroent., *31*:438, 1959.

A-H-ROBINS

A. H. Robins Company, Inc.
Richmond, Virginia 23220



"CLEAR THE TRACT" WITH

Coughing ahead...
Clear the Respiratory Tract with Robitussin.

Much more than just a slogan, "clear the tract" reflects the dependable antitussive-expectorant action of the three Robitussin formulations. All contain glyceryl guaiacolate, the time-tested expectorant that greatly enhances the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Glyceryl guaiacolate is safe, non-narcotic, and almost universally accepted by patients of all ages.

NOW! THREE ROBITUSSIN FORMULATIONS	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM
EXPECTORANT	●	●	●
DEMULCENT	●	●	●
COUGH SUPPRESSANT		●	●
ANTIHISTAMINE		●	
LONG-ACTING (6-8 hours)			●

FORMULAS

ROBITUSSIN®
in each 5 cc. teaspoonful:
Glyceryl guaiacolate 100 mg.
(Alcohol 3.5%)

ROBITUSSIN® A-C
(exempt narcotic)
in each 5 cc. teaspoonful:
Glyceryl guaiacolate 100 mg.
Pheniramine maleate 7.5 mg.
Codeine phosphate 10.0 mg.
(warning: may be habit forming)
(Alcohol 3.5%)

ROBITUSSIN®-DM
new, non-narcotic
in each 5 cc. teaspoonful:
Glyceryl guaiacolate 100 mg.
Dextromethorphan hydrobromide 15 mg.

Robitussin and Robitussin-DM are available at pharmacies everywhere on your prescription or recommendation.

A. H. Robins Company, Inc. Richmond, Va.

OUR PHOTO:
Engine No. 89 of the Monadnock, Steamtown & Northern Railway pulls a trainload of steam enthusiasts through the New England countryside between Bellows Falls and Chester, Vermont.

A·H·ROBINS

IT ONE OF THE ROBITUSSIN® FORMULAS

...but doctor, I eat like a bird!



IN WEIGHT CONTROL

OBETROL®

Each OBETROL-10 tablet contains: Methamphetamine Saccharate; 2.5 mg. Methamphetamine Hydrochloride; 2.5 mg. Amphetamine Sulfate; 2.5 mg. Dextro-amphetamine Sulfate; 2.5 mg. (OBETROL-20 tablets contain twice this potency) Pat. #2748052.

INDICATIONS: This combination of amphetamines may be useful as an adjunct in the management of certain forms of obesity where an appetite depressant is indicated.

CONTRAINDICATIONS: Hypertension, advanced arteriosclerosis, coronary artery disease, cardiac arrhythmias, peripheral vascular disease, states of undue restlessness, anxiety, excitement, agitated depression, hyperthyroidism, idiosyncrasy to amphetamine, concomitant administration of a monoamine oxidase inhibitor.

SIDE EFFECTS: The most common side effects attended with the use of amphetamines include nervousness, excitability, euphoria, insomnia, dryness of mouth, nausea, vertigo, constipation, and headache.

DOSAGE: Initial adult dose is one-half to one 'Obetrol-10' tablet daily, preferably one-half to one hour before meals. This may be gradually increased to one 'Obetrol-10' or 'Obetrol-20' tablet, one to three times daily as indicated.

SUPPLIED: In bottles of 100, 500, and 1,000 scored tablets.

REQUEST SAMPLES AND LITERATURE

Obetrol Pharmaceuticals • Brooklyn 7, N.Y.

Dr. _____

Address _____

City _____ State _____

OBETROL PHARMACEUTICALS
Div. of Rexar Pharmacal Corp.
Brooklyn 7, N.Y.

An antibiotic of choice is one that works

TAO works

Susceptibility Results
Staphylococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
6,725	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

The Product

In a world study of antibiotics *in vitro*[1], TAO had an overall effectiveness of 87.3%, higher than chloramphenicol and erythromycin, and significantly higher than tetracycline and penicillin.

The Plus... Consistent Performance

Yet antibiotics must not only work. They must work consistently. Here are the results from the largest study of microbial susceptibility ever undertaken. In 29,048 cultures of overt staphylococcal and β-hemolytic streptococcal infections, note the consistency of results with TAO.

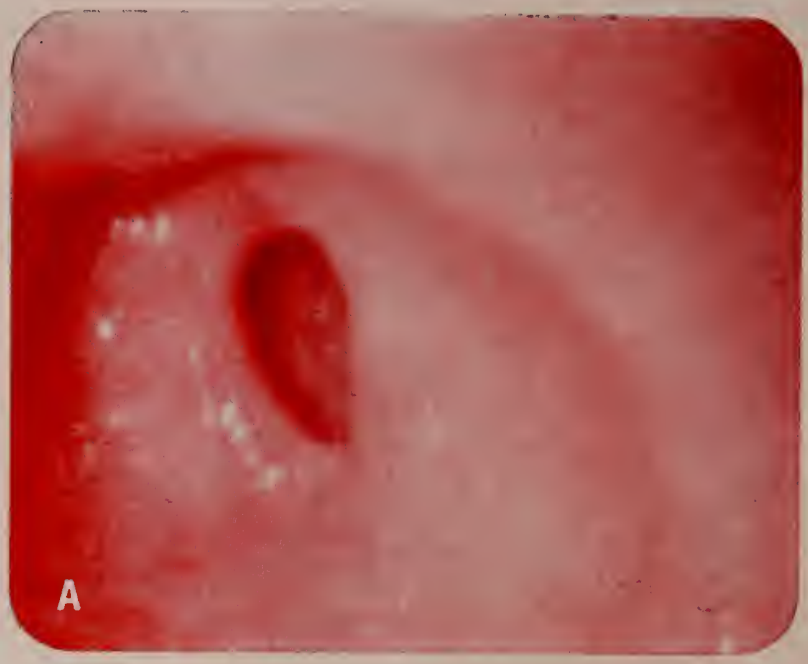
TAO®
[triacetyloleandomycin]

ROERIG

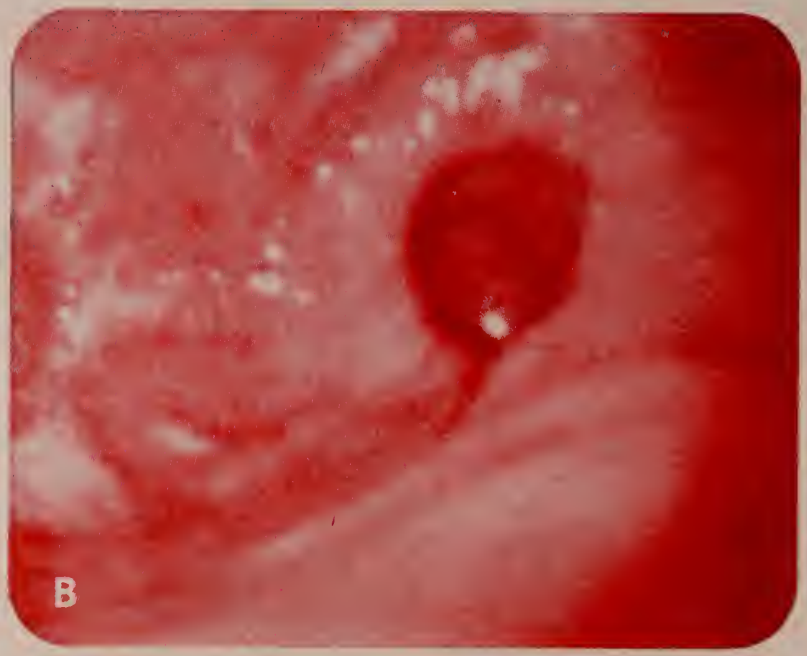
J. B. Roerig and Company, New York, New York 10017
Division, Chas. Pfizer & Co., Inc., Science for the World's Well-Being™

TAO Rx information

Indications: The bacterial spectrum includes: streptococci, staphylocci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **Contraindications and Precautions:** TAO (triacetyloleandomycin) is not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents, of course, should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. It is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. **References:** 1. Isenberg, Henry D.: Health Laboratory Science 2:163-173 (July) 1965. 2. Fowler, J. Ralph et al: Clinical Medicine 70:547 (Mar.) 1963. 3. Isenberg, Henry D.: Health Laboratory Science 1:185-256 (July-Aug.) 1964.

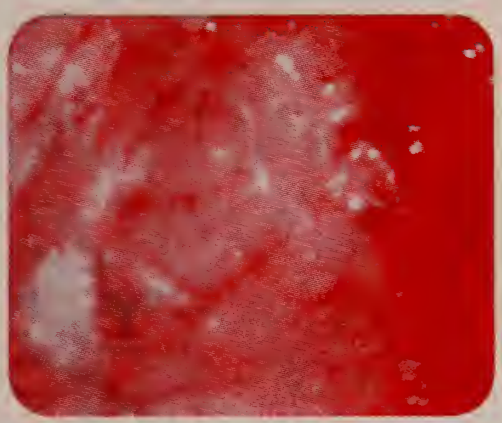


Which Is Pyloroplasty with Vagotomy?
Which Is Pro-Banthine?



Photographs—Harry Barowsky, M.D., Lawrence Greene, M.D., and Robert Bennett, M.D., from a Scientific Exhibit presented at the Annual Meeting of the American College of Gastroenterology, Bar Harbour, Florida, Oct. 24-27, 1965.

Another example of
Pro-Banthine®
(propantheline bromide)
a true anticholinergic in action



Normal relaxed pyloric antrum; contracted pylorus (pyloric fleurette)

The true anticholinergic values of Pro-Banthine have never been so graphically realized as they are with the recent development of fibergastroscopy and the intragastric camera.

Pro-Banthine consistently produces complete relaxation and immobility of the stomach with a dose of only 6 to 8 mg. intravenously. This is less than half the usual dose orally.

Atropine, on the other hand, required 0.8 mg. intravenously, or twice the normal dose, to achieve a similar effect. This high dose of atropine resulted in expectedly adverse side effects.

Pro-Banthine, in minimal dosage, produces effects similar to pyloroplasty and vagotomy without the disadvantages of permanent post-vagotomy sequelae.

The intragastric photograph A is of a patient who has had pyloroplasty with vagotomy. Photograph B is of a patient given 6 mg. of Pro-Banthine.

Indications: Peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

Oral Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

Side Effects and Contraindications: Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. Pro-Banthine is contraindicated in patients with glaucoma, severe cardiac disease and prostatic hypertrophy.

SEARLE

Research in the Service of Medicine





So I said, "All right, Raymond, if you don't take your cough medicine this minute, I'll call Doctor Peabody."

Controlling the child is sometimes as big a problem as controlling his cough. But with most children and with most coughs, the job is usually much easier with one of these effective Novahistine formulas.

If it's the useless, exhausting type of cough that often accompanies respiratory infection or allergy, you can provide prompt relief with Novahistine DH. Its decongestant-antitussive action controls frequency and intensity of cough spasms without abolishing cough reflex. And the fresh grape flavor of Novahistine DH appeals to children and adults alike.

When your diagnosis is bronchitis, complicated by thick tenacious exudates, Novahistine Expectorant is particularly useful. It not only provides decongestive action and controls the cough, but also encourages expectoration, thus easing bronchial obstruction.

Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.

Each 5 ml. teaspoonful of Novahistine DH contains codeine phosphate, 10 mg. (Warning: may be habit forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, 2 mg.; chloroform (approx.), 13.5 mg.; l-menthol, 1 mg. (Alcohol 5%). Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

NOVAHISTINE® DH

NOVAHISTINE® EXPECTORANT

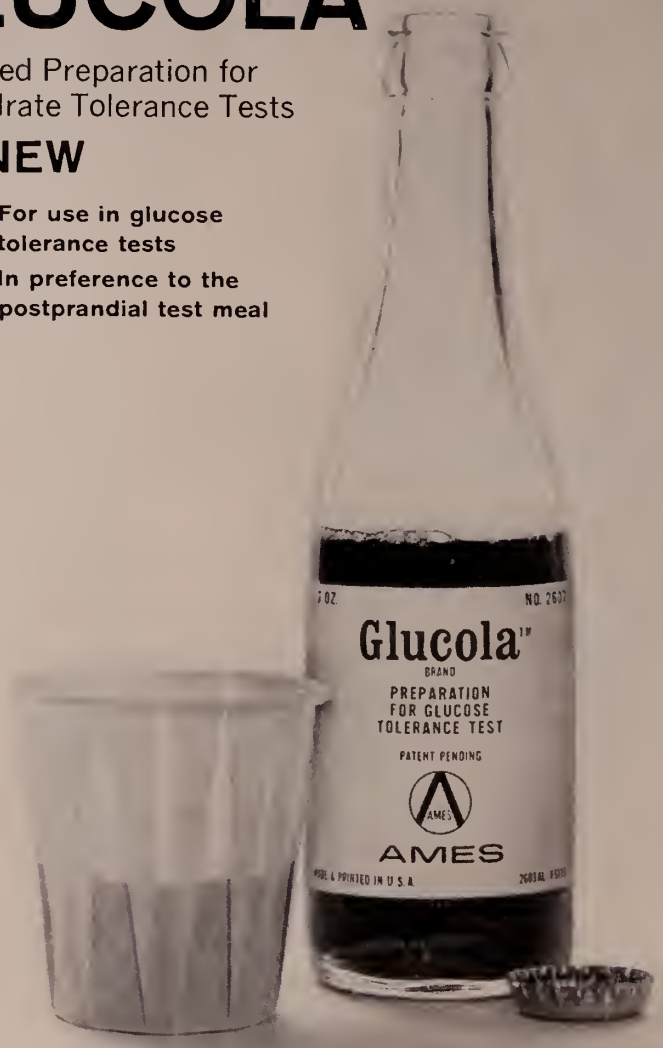
DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

GLUCOLA™

Carbonated Preparation for
Carbohydrate Tolerance Tests

NEW

- **For use in glucose tolerance tests**
- **In preference to the postprandial test meal**



A NEW SOLUTION FOR AN OLD PROBLEM

Ready to use • Pleasant tasting cola flavor • Well tolerated

A 7-ounce bottle of GLUCOLA provides a liquid oral loading dose equivalent to 75 Gm. of glucose* for carbohydrate tolerance testing. GLUCOLA avoids the nausea that frequently results from lingering sweet laboratory preparations, and the occasional emesis that necessitates rescheduling the test. With GLUCOLA, no time is lost weighing and mixing glucose "cocktails"—only a bottle opener is needed.

753(R2)64

*The rapidly hydrolyzable saccharides in this formulation assure optimum absorption and glucose levels comparable to those obtained with a 100 Gm. loading dose.

Available through your regular supplier:
cartons of 12 7-oz bottles (6 bottles per pack, 2 packs per carton).

Ames Company, Inc.
Elkhart, Indiana

AMES

2½-3 times more potent than papaverine with a longer duration of action

NON-NARCOTIC

SPACOLIN™

(Alverine citrate)

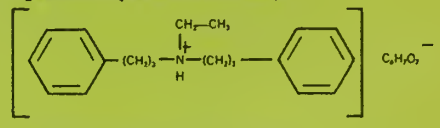
is a potent smooth muscle antispasmodic particularly effective in relieving spastic colon* and spasm of the biliary tract.

*"The diagnosis is based upon a history of catharsis or enema habit, dietary indiscretion or emotional strain, generalized or lower abdominal distress of the type described, abnormality of the bowel movement and tenderness along the course of the colon." *Cecil and Loeb, A Textbook of Medicine, Tenth Edition*

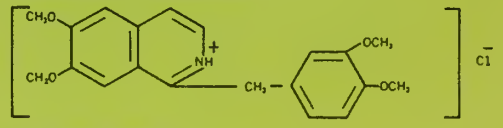


The chemical structures of Spacolin, Papaverine and Atropine are as follows:

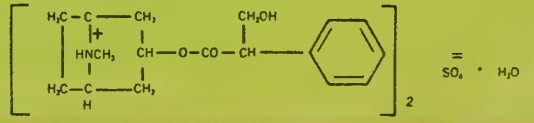
Spacolin (Alverine citrate)



Papaverine Hydrochloride



Atropine Sulfate



SPACOLIN™ *(Alverine citrate)*

- A specific musculotropic counter-spasmodic.
- NOT an anticholinergic, therefore, has no atropine-like side effects.
- In man, its spasmolytic effect is two and one/half to three times stronger than papaverine with a longer duration of action.
- Neurotropic effect only 1/150 that of atropine.
- Has little or no effect on normal muscle tonicity and motility.
- Specific effect on the *sphincter of Oddi.*
- Mild local anesthetic effect and decreases gastric acidity.



NON-NARCOTIC

For fast relief of spasm

PRODUCT INFORMATION

Each tablet contains: Alverine citrate (Bis-gamma-phenylpropylethylamine citrate) ..... 120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in **spastic colon,** spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer†, cardiospasm, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations.

†Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, cardiospasm or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort.

PRECAUTION: Caution is recommended when using in hypotensive patients.

SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

SUPPLIED: Bottles of 100 and 500 — 120 mg. tablets.

PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
"First with the Retro-Steroids"



This non-profit $2 million center offers your patients all three kinds of nursing care

The 90-bed Meadow Lakes Nursing Care Center in Hightstown, New Jersey (near Princeton), provides the most comprehensive residential, convalescent and rehabilitative nursing care available anywhere—combined with modern facilities and professional services ordinarily associated only with hospitals.

- Patients cared for by a staff of 38 Registered Nurses and experienced, carefully-screened nurses aides. RNs supervise patient care 24 hours a day.
- Medical facilities include x-ray, dental, examination, laboratory and testing equipment and rooms, pharmacy, supervised bathing rooms — and fully-equipped Department of Physical Rehabilitation (diathermy, hydrotherapy, massage) under direction of licensed Physical Therapist.
- Each handsomely furnished and decorated room opens on landscaped patios and grounds. Center completely air conditioned.
- Private rooms $165 per week; semi-private rooms $125 per week.
- Excellent food prepared in $500,000 kitchen — operated by world-famed Stouffers, Inc.
- Highly-qualified local physician is staff doctor, along with two associates. Ambulance service to nearby Princeton and Trenton hospitals on call.
- Activities offered in 4 large solariums and day rooms (2 also used as dining areas). Nurses and visiting Junior Volunteers help keep patients occupied and interested. Recreational and special services of Meadow Lakes Village are available.

For more information, write or call Ellis G. Willard, Executive Director, (609) 448-4100.

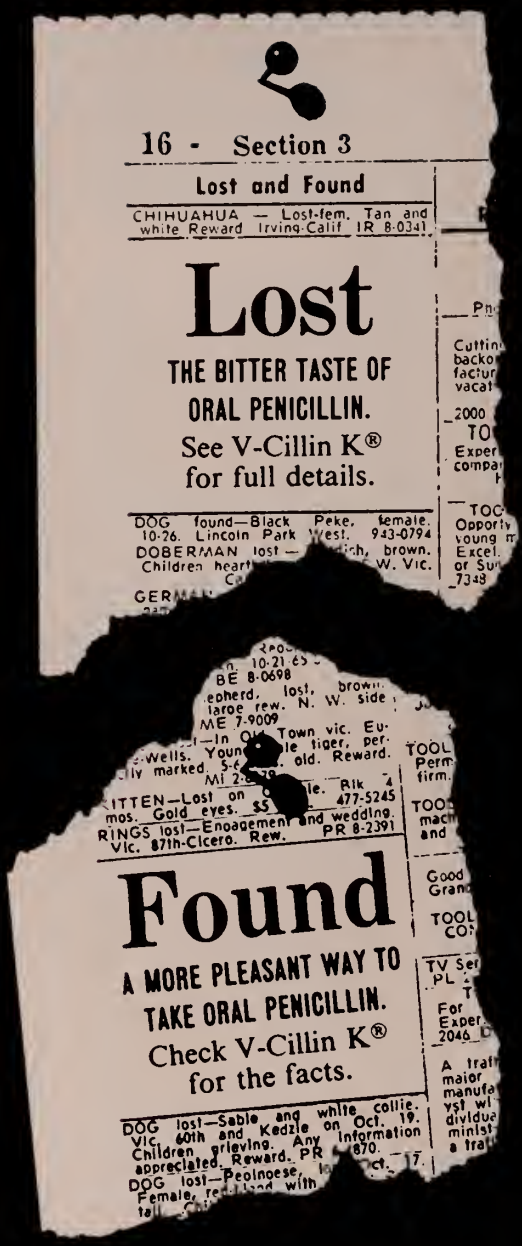
Meadow Lakes Nursing Care Center

Etra Road, Hightstown, New Jersey

owned and managed by

The Presbyterian Homes of the Synod of New Jersey, Inc.





Patients won't complain about bitter penicillin taste when you specify V-Cillin K. Here's why: It has a special coating, only one and a half *thousandths* of an inch thick. Because it is designed to dissolve after approximately six seconds, this barrier to bitterness remains on the tablet as it slides past the tongue. When the tablet reaches the stomach, however, the coating has dissolved, and the penicillin is ready for immediate absorption into the bloodstream.
Result? The proved efficacy of potassium penicillin V without the penalty of bitter taste.

Indications: V-Cillin K is an antibiotic useful in the treatment of streptococcus, pneumococcus, and gonococcus infections and infections caused by sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

Lilly

V-Cillin K®
Potassium Phenoxymethyl Penicillin

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana.
600050

EDITORIALS

Rutgers And Us: Fifty Years Ago

The following editorial appeared in the February 1916 issue of this JOURNAL. It was part of our sesquicentennial celebration. Now that we have reached the age of 200, we reprint our 1916 editorial:

It is a singular coincidence that this college and our Society were both founded in the same year — 1766 — and that, therefore, we both celebrate this year our 150th anniversary. We extend to the president, trustees, and faculty of Rutgers College our heartiest congratulations, not only because we recognize the fact that our histories have been running for an equal period of time, but also because of the splendid record that college has made and its brightening prospects, under the presidency of The Reverend Dr. W. H. S. Demarest, of still greater progress in the near future. And we recall another fact that, during all the past years, this college and our Society have both been striving for higher standards of education.

The college number among its alumni many men of national and some of worldwide reputations. Our Society's membership, past and present, has a goodly proportion of its graduates whose ability, character, and success bear testimony to the excellent preparation this college gave them in securing their medical education. In its early infancy, the college had a medical school with able professors; but its finances were inadequate and there were no millionaires to encourage higher education of medical men. The wise men at its head determined that if it *could not* conduct a first-class medical department, it *would not* continue as an inferior school. Would that the 65 medical schools that have been compelled to go out of existence the past few years had had as wise men a few decades earlier and ceased voluntarily, or better, that some of them had never organized. The college has been called a *small* college, but it is *growing bigger* every year.

(This was written a year or two after the famous Flexner report had led to the abandonment of 65 "diploma-mill" types of medical schools.)

Invading That Last Frontier*

Biotelemetry may be all Greek to you—but you had better become familiar with it. The next generation of medical students will speak of it the way we now talk of taking blood pressures. The word comes from *bios* (life), *metren* (to measure), and *tele* (at a distance). It is a way of measuring life activities in inaccessible locations. It may mean taking the pulse of an astronaut who is inaccessible because he is thousands of miles out in space. Or measuring the rate of flow within the aorta of a man in the same room—inaccessible because you can't invade the artery the way you can look into the bladder with a cystoscope. Or inaccessible in an economic sense, as when you want to maintain a continuing record of temperature, but can't afford to pay for around-the-clock nurses to keep on putting in, removing, and reading thermometers.

A patient in a hyperbaric chamber is inaccessible; many parts of a patient undergoing surgery are inaccessible because you can't remove the drapes without breaking steril technics. For that matter, a fetus *in utero* is inaccessible in the ordinary sense, too. So biotelemetry has lots of use among patients here on earth.

The modern intensive care ward has forced the development of telemetry. Taking a blood pressure every hour with the old-fashioned rubber cuff and the human eyes-and-ears seems an intolerably slow and error-prone method when you need continuous and pre-

* You can learn all about it by sending 45¢ to the U. S. Government Printing Office, Washington, D.C. 20402 and asking for NASA-SP 5023, "Medical and Biologic Applications of Telemetry."

cise readings. Refined biotelemetric methods make the electrocardiogram and even the electro-encephalogram look primitive in structure and gross in reading. The complex surgery of today's operating room requires an anesthesiologist to note at once many subtle, instantly available, precise measurements from areas once considered inaccessible to measuring devices.

Biotelemetry is useful even in the doctor's office. Many "minor" procedures require—or should require—constant physiologic monitoring. If electrocardiographic equipment can be made without wires, small and unrestrictive of the patient's movements, it will be a more useful office device than the present EKG instrument. And here is an area for the newer telemetry.

It is, perhaps, in the brain that the possibilities of telemetry become most awesome. If the brain output is controllable, the face of the world will be changed. Already, we can implant electrodes into the brain and learn a lot about fear and feeding, about sex and salivation. And through these electrodes we can invoke strange or familiar reactions and eventually mould behavior. If we can probe the oddities of reactions in space flights, we can probe the oddities of the person in the mental hospital. If we manipulate the one kind of behavior, we can learn to manipulate the other. We should be able to make the meek animal—and soon the meek human being—an aggressive one or tone down the aggressiveness of a dominant one. May we not thus be able to re-arrange the behavior patterns of the criminal, facilitate learning, elevate moods?

One by-product of biotelemetry is the physician's dependence on other scientists, on technologists, and on engineers. In the past, medical practitioners have downgraded the concept of a "medical team" because of their conviction that responsibility always had to be centralized in the M.D. But telemetry requires working together—as equals—on the highest plane.

The electronic devices are inhuman. So they are patient, tireless, devoted to their functions, quiet, free of emotional involvement, and blessed with a good memory.

Perhaps the phrase "brain washing" will thus lose its metaphoric character.

Narrative Reports vs. Questionnaires

Those who dream up questionnaires mean well; and it is certainly easier to score a returned questionnaire or check sheet than to appraise or compare narrative reports. On the other hand, most of us have developed a sensitivity reaction to questionnaires. Furthermore, we are at home with the traditional narrative history for medicine and surgery. What this lacks in structural uniformity, it makes up in giving the doctor freedom of expression.

So we welcome the decision of the Social Security Administration* to encourage physicians to send in their report on a form that looks comfortably like the traditional "medical history" that we have become accustomed to.

Incidentally, our profession has other contributions to make to the program. You can advise the patient that he may have an entitlement to benefits here. (Write to the Rehabilitation Commission at 309 Washington Street, Newark 07102 for details.) You can volunteer your services both as a consultant and as an advisor so that you can help orient administrative procedures toward the medical community. And you can help motivate the patient to participate in, and follow through on, the rehabilitation opportunities.

We may have reservations about government programs, but in this one at least, we have every opportunity to participate.

* See Social Security Disability Reports on page 56 of this issue.

ORIGINAL ARTICLES

In this unique study, the Gordons cite evidence that there is such a phenomenon as preventive psychiatry.

Is Short Term Psychotherapy Enough?

Richard E. Gordon, M.D.
Katherine K. Gordon, R.N., M.A.
Englewood

The pediatrician who schedules regular checkups for his patients gets a chance to detect and manage childhood ailments in their early stages and to immunize against preventable diseases. The internist keeps careful watch over persons who have a history of illness; he does not wait until they are in diabetic coma or cardiac failure before treating them. By infrequent, but periodic office examinations, he tries to prevent complications from developing.

Why not the psychotherapist? Perhaps he would serve his patients best by extending his treatment with those who have recovered from their acute disorders. Instead of discharging patients outright, he might — like the internist, pediatrician, and dentist—schedule them for regular check-ups. Thus, he, too, might reduce patients' tendency to relapse. Wolf,[5] in reporting on the Minnesota Follow-up Study, discusses the benefits of "keeping in touch" with former mental patients in reducing their return rate to the hospital. Caffey[1] is investigating the usefulness of follow-up pharmacotherapy with Veterans Administration psychiatric patients. In this paper we explore a preventive approach which includes extensive psychotherapy and pharmacotherapy. Instead of brief psychotherapy alone, patients continued to receive periodic sessions of anticipatory guidance.

Anticipatory Guidance in Preventive Psychiatry

People at transition periods in their lives (e.g., students entering college, expectant parents, and so on) are receptive to counseling. Those who are not emotionally upset readily accept practical suggestions about making plans to avoid excessive stress. In careful studies, experimental groups of expectant mothers were shown how to manage the emotional crisis of first parenthood. In the postpartum period, each instructed group had less emotional distress than its matched control. More than that, follow-up studies showed that counselled women were healthier and happier five years later. Simple but timely prenatal instruction had a lasting effect upon the family's physical and mental health; years later, significantly more counselled women than controls bore healthy second and third babies without emotional strain; and fewer experimental subjects suffered physical illnesses, marital conflicts, sex problems or divorces.[2] Obstetricians, family doctors, and public health nurses were as effective as a psychiatrist in counseling these women.[2,3]

We have made similar observations on beginning high school and college students. Practical guidance,[4] given in personal development courses by psychologists, personnel deans, and health educators, as well as by a psychiatrist, produced significant improvements in experimental groups' grades, health, and conduct. Prevention apparently is easier than cure with many psychiatric problems,

just as with those in pediatrics and internal medicine.

Anticipatory Guidance with Psychiatric Patients

Psychiatric patients, like those with purely physical diseases, frequently relapse after being discharged following successful treatment. Psychiatric relapses often occur at new transition phases of patients' lives. If occasional sessions of relatively simple anticipatory guidance at critical periods can prevent emotional problems with students and young mothers, might not similar preparatory counsel reduce the relapse rate among improved psychiatric patients?

A few years ago, we began to collect information on this subject. The patients studied were typical of those seen for short-term office psychotherapy in a socially mobile middle class suburb. They were mostly people of modest incomes with serious emotional and mental disorders – severe neurotics, patients with major character disorders, psychotics, and others with psychosomatic disease. They came no more than once a week for less than ten visits during their primary treatment period. These patients did not receive intensive psychotherapy. However, we suggest that the findings obtained would also apply to patients treated initially by psychoanalysis or other psychotherapeutic procedures. The patients in this report received their treatment from a psychiatrist. We suspect, however, that the same results could be obtained by experienced family doctors and other counsellors.

In the present survey, one group of private patients who had received and benefited from short term office psychotherapy and pharmacotherapy were discharged outright by agreement between patient and doctor. These "controls" received instructions to call for an appointment only if further treatment was necessary. A second group of office patients were *not* discharged after initial improvement. They were continued in extensive† psychotherapy and were given appointments—first at monthly, then tapering off to bimonthly, trimonthly, and finally, at regular six month intervals. In the past three years, twenty-nine of these experimental subjects have kept their follow-up appointments, which were also timed to help them discuss and prepare for forthcoming crises. Twenty seven "controls" returned for further psychiatric treatment only when they felt emotionally ill again.

This survey contains no rigorous "controls" for many important variables. For example, many experimental subjects discontinued treatment when they felt better, despite the recommendation to continue; similarly, many controls have not sought further treatment from us.

We have no follow-up information on either of these groups, both of which may contain well members and sick ones who have sought psychiatric treatment elsewhere. The "controls" in the study, moreover, were all sick, while the experimental group contained both potentially ill patients and others who may never have relapsed. Moreover, no effort was made to match the two groups by age, sex, marital status, nor exact number of psychiatric treatments. These obvious biases could be removed only by a thorough-going, long-term, expensive research. This would involve much larger matched samples of experimentals and controls, and careful follow-up of all patients, well and sick, over a number of years.

The patients and their relatives provided social information regarding six objective "indicators" which are generally considered to be related to social and emotional adjustment. These included: (1) Need for rehospitalization of patients who previously had been hospitalized for psychiatric illness; (2) Continuation of marriage in married patients; (3) Return and continuing stay in college with college dropouts; (4) Return and continuing stay in school with school dropouts; (5) Further arrests and convictions with those who had been convicted of a crime; (6) Improvement or decline in job status among those who were employed.

Findings with Extensive Psychotherapy

The experimental subjects have now continued their semiannual therapeutic and preventive consultations for at least one year. Some have been returning for as long as three years. Observations with these patients' indicators were compared to those of controls who had been discharged from treatment but returned for further care during this same period. The findings of this survey are shown in the table.

† "Extensive: Extended widely in space, time, or scope."

Among the 29 experimental subjects, 36.5 per cent of the indicators showed that patients continued to improve with extensive psychotherapy; only four per cent of their indicators suggested relapse. In contrast, among the 27 patients who were discharged as recovered but had to return for further psychiatric treatment, the proportions were reversed: 51½ per cent of the indicators showed personal and social gains in the period after treatment ended, while 37 per cent pointed to objective deterioration in the patients' life situation.

Specifically the findings were as follows:

Of twelve who had been in mental hospitals, five had been continued in extensive psychotherapy while 7 were discharged after short therapy. Not one of the five in the "experimental" group had to return to a mental hospital; but 6 of the 7 on short-term therapy had to be rehospitalized.

Marriage was terminated among 5 of the 22 who had been married but who had not had consistent extensive therapy. Of the 18 in the "experimental" group, 17 marriages remained intact.

Six of the "extended psychotherapy" patients had been college drop-outs, and all six returned to college. Both of the 2 college drop-outs in the "control" group remained as drop-outs. Three in the control group and three in the experimental group had had convictions for antisocial action. Two of the "controls" but none of the "experimentals" had subsequent convictions. Of 17 experimental subjects who had been working at the start of the project, only one was unemployed at the time of the survey. Of the 19 in the "short-term-therapy" group, only 12 were able to keep the same job or hold a better one.

Benefits to the Patient

Former psychiatric patients, as a rule, even when they are not emotionally upset are generally more sensitive than norms. As a result of interacting constitutional burdens and environmental sensitization, expatients tend to overreact emotionally and physiologically to life's stresses. These handicaps often impair patients' personal and social skills. Neurotics, psychotics, and those with character disorders, even when not acutely distressed, will frequently behave impulsively, impatiently, or in a socially undesirable manner when faced with adversity. Rather than persevering effectively and continuing to cope with problems when frustrated, they often become dejected or withdrawn. Emotional and personality defects interfere with patients' judgment. Bad decisions lead to failures and new personal injuries; further hurts damage already vulnerable emotions. Relapses occur; former patients become sick once again.

With rational patients, recovered from their acutely disturbed states, the psychotherapist might be able to influence favorably every stage of this process and to prevent the cycle from becoming a vicious one. In very mobile communities, such as the one we have continuously studied, many people constantly move their homes and their social standings. They expose themselves repeatedly to new pressures and crises. The psychotherapist, trained to be alert to the stress of transition periods, might help expatients anticipate and guard against new misfortunes.

Long before the problem arises, for instance, the doctor could help the middle-aged house-

TABLE

Continued in Extensive Therapy Indicator Status					Discharged after Short-term Therapy Indicator Status			
Number	Better	Same	Worse		Better	Same	Worse	Number
5	—	5	—	Not rehospitalized	—	1	—	1
0	—	—	0	Rehospitalized	—	—	6	6
17	—	17	—	Marriage remained intact	—	17	—	17
1	—	—	1	Marriage terminated	—	—	5	5
6	6	—	—	Returned to college	0	—	—	0
0	—	0	—	Remained a drop-out	—	2	—	2
3	3	—	—	Returned to high school	0	—	—	0
0	—	—	0	Remained a school drop-out	—	1	—	1
3	—	3	—	No new convictions for unlawful action	—	1	—	1
0	—	—	0	New convictions	—	—	2	2
10	10	—	—	Has a better job	3	—	—	3
6	—	6	—	Kept same job	—	9	—	9
1	0	0	1	Worse job or unemployed	—	—	7	7
52	19	31	2	Indicator totals	3	31	20	54
100%	37%	59%	4%	Indicator percentages	5%	58%	37%	100%

Occurrence of Important Social Indicators in Lives of Psychotherapy Outpatients. With every indicator, the group who were discharged after initial improvement subsequently fared worse than those who returned for extensive psychotherapeutic sessions at regular monthly to semi-annual intervals.

wife whose children are about to leave the community for college or marriage to find ways of filling the coming void in her life. He could coach the young executive, helping him prepare in advance for the new responsibilities his hoped-for promotion will bring. The single patient about to be married, perhaps to a woman of different religious or social background, could bring in his fiancee for premarital discussion; the elderly couple hoping to retire in the South could talk over their plans for finding new friends and developing new interests.

Aware of patients' character weaknesses and experienced in teaching the development of strengths, the doctor could help them use effective defenses, think clearly, and act sensibly, rather than just react emotionally. He would aid them in reorganizing their lives and personalities so as to increase wholesome pleasures, reduce excessive pressures, and use energies constructively.

The Doctor's Satisfactions

Unlike the architect, the psychotherapist ordinarily cannot savor the fruits of his effort when patients regularly leave his care once they recover from the acute phase of their emotional upset. Moreover, after he has labored to help them and has discharged them from treatment, he, too, is pained to see them return a year or two later, just as sick as before. However, if he should continue to guide his patients, extending his psychotherapy with them to good times as well as bad, his enjoyment in aiding their return to normal would be enhanced by his pleasure in helping them achieve new triumphs and avoid further remissions. The feedback he would get from extensive psychotherapy patients would help him assess and improve his methods of anticipatory guidance and psychotherapy.

Dependency Upon the Doctor

We may ask: "Is the psychotherapist fostering dependency in patients by continuing to have them come to see him year in and year out?" The same question can be put to other professional workers. The lawyer gives his clients periodic office appointments to review their important contracts, wills, and other legal matters. By so doing, he keeps them out of court and painful litigation. Likewise, the accountant sits down regularly with his clients in the annual ritual aimed at avoiding conflict with the Internal Revenue Service. Does the psychotherapist foster dependency any more than other professional people when he seeks to prevent future emotional relapses by six-month checkups?

Extensive psychotherapy offers more to patients than short term psychotherapy alone. We see no evidence that the former fosters dependency; yet many patients enjoy keeping their semi-annual appointments. Certainly the experience has hurt nobody. No one objected to the cost, which was minimal when compared to the toll paid by discharged patients who subsequently relapsed.

Summary

This paper reports observations about extensive psychotherapy with patients who ordinarily would have been discharged after short-term psychotherapy. One group of patients who were given periodic appointments for anticipatory guidance and psychotherapy at regular but infrequent intervals were helped to prepare for and manage new crises in their lives with little emotional turmoil. Discharged patients, on the other hand, who returned for further psychiatric help only after they needed it waited too long. Most of these controls were already in complicated social difficulties, and had suffered serious exacerbations of their illnesses before they came again for psychiatric help. We have described some of the benefits of extensive psychotherapy both to the patient and the doctor. We hope that other psychotherapists, both researchers and clinicians, will explore its usefulness.

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275 Grand Avenue

While packed cell transfusion may be safer than whole blood, this is not entirely a danger-free procedure, either.

Pulmonary Edema Following Packed Cell Transfusion

Report of a Case

Erwin O. Hirsch, M.D.
Antonio R. Caracta, M.D./**Perth Amboy**

Congestive failure and deaths due to congestive failure[1] have resulted from the administration of whole blood to patients with chronic anemia.[2]

When packed red blood cells (rather than whole blood) are transfused, the load on the circulation is reduced as is the amount of sodium (and potassium) contained in citrated plasma.[3] Slow administration, with the patient in the semi-upright position, is thought to add to the safety of packed cell transfusions. For these reasons, packed cells are frequently given to patients with pernicious anemia when the hemoglobin is 5 Grams or less and when the clinician fears that congestive failure may develop before specific therapy can be expected to result in an adequate hemoglobin response.

Recently, Duke *et al.*[4] reported that venous pressure and cardiac output were not unfavorably affected in six patients with chronic anemia given packed cells at rates up to 19.5 milliliters per minute. Although a further rise in venous pressure and a drop in cardiac output occurred in two patients whose venous pressure was elevated prior to transfusion, no untoward symptoms developed in these two. Nor were we able to find in the medical literature any cases of actual congestive failure or deaths due to failure, following packed cell transfusion.

The following case report emphasizes the reality of the hazards of packed cell transfusions in pernicious anemia even if recommended precautions are taken.

A 76-year-old woman was admitted because of varicose ulcers and chronic anemia. For two years before admission, she had been treated with digitalis and diuretics. On admission, there was no dyspnea or orthopnea. The left heart border was percussed at the anterior axillary line in the 6th interscape. The cardiac rhythm was regular. There was a soft blowing systolic murmur over the precordium. Lungs were clear to percussion and auscultation. Neck veins were not engorged, and there was no peripheral edema. The liver was not palpable. Blood pressure was 130/60. X-ray showed enlargement of the heart with accentuation of pulmonary vasculature at both bases. Transverse diameter of the chest was 26 centimeters. Transverse diameter of heart was 15 centimeters.

Laboratory findings were as follows: hemoglobin: 5.6 grams per 100 milliliters; hematocrit: 17 vol. per cent; white blood cells: 3.3 thousand per cubic millimeters; red blood cells: 1.5 million per cubic millimeters; platelets: 280,000; reticulocytes: 0.7 per cent. Differential count: band cells: 2 per cent; segmented neutrophils: 65 per cent; eosinophils: 2 per cent; lymphocytes: 28 per cent; atypical mononulcear cells: 1 per cent; monocytes: 2 per cent. The red cell morphology was characterized by marked poikilocytosis and anisocytosis with scattered macrocytes suggestive of pernicious anemia.

The bone marrow showed marked erythroid hyperplasia with megaloblastic maturation. In the myeloid series there were giant metamyelocytes and giant band forms. The bone marrow was interpreted as consistent with pernicious anemia.

The electrocardiogram showed regular sinus rhythm with a rate of 90. Except for a small Q wave in Leads III and aVF, the tracing showed no abnormalities.

Blood sugar: 104 mg. per cent. BUN: 12 mg. per cent. Total blood volume: 4320 cubic centimeters. (Predicted: 4000-4291 cubic centimeters.) Red cell volume: 472 cubic centimeters. (Predicted: 1750-1877 cubic centimeters.) Plasma volume: 3848 cubic centimeters. (Predicted: 2550-2414 cubic centimeters.)

Twenty-four hours after admission, a transfusion of 250 cubic centimeters of packed cells was started with the patient in the semi-upright position. Infusion was completed in three hours (1.4 milliliters per minute) and a second infusion of 250 cubic centimeters of packed cells was started. Three and one-half hours later, the nurse noted a pulse of 68. Five minutes later, with only half the second unit of packed cells transfused (rate 0.6 milliliters per minute), the patient suddenly became restless and dyspneic with frothing at the mouth. The infusion was stopped at this point; but before medical intervention could reach her, she died. Permission for autopsy was refused.

A patient with pernicious anemia and asymptomatic cardiac failure is described. Because her situation was precarious, slow transfusion with packed cells was elected to raise her hemoglobin level. Fatal pulmonary edema developed, believed to be due to the transfusion.

While the dangers of whole blood transfusions in patients with pernicious anemia are well known, no other actual case of death due to congestive failure following packed cell transfusion has been recorded in the literature as far as we have been able to ascertain. The case described here emphasizes the real danger associated with packed cell transfusion in patients with pernicious anemia, even when recommended precautions are taken.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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A brain damaged child may have good, even superior, intelligence. He needs a team of diagnostic and treatment experts with a good clinician as captain of that team.

The Diagnosis Of Minimal Brain Damage

Suzanne Allen Widrow, M.D./Hanover

The weakness of the concept of the "minimally brain damaged" child lies in the nonspecific nature of the symptoms. The phrase conveys no precise concepts. The term "minimal damage" has been used by a variety of people to imply many different etiologies and cannot be construed as meaning one particular entity. Here, I will limit our discussion to the brain damaged children whose intellectual levels range from near normal to above normal; who exhibit no gross neurologic defects but who have behavioral and/or learning difficulties secondary to physiologic dysfunction, maturational delay, underdevelopment, or actual tissue damage in the portions of the central nervous system having to do with perception, language, inhibition of impulses, and motor control.

The extent of this problem is not known but it has been estimated[1] that 5 percent or more of the total elementary school population falls into this category. It is the responsibility of the physician in cooperation with the parents and schools to find these children. Diagnosis should be made early to make available the specialized help that the child needs. Early diagnosis is also desirable to prevent secondary emotional problems and complications which can overwhelm him.

The tendency in all children is toward normal maturation. The brain damaged child tends to show improvement as he grows older, provided he receives sufficient support, understanding, and training to overcome his individual difficulties, though subtle residual signs of the original injury remain.

Early diagnosis of brain damage implies a comprehensive knowledge of the way in which the newborn infant, baby, toddler, pre-school, and school child behave and react at these different stages of development. Clinicians have long been aware that evidence of early neurologic abnormalities can be obtained by history, as well as by physical examination. For this reason, the physician must get a meticulous gestation and developmental history. This includes maternal health, especially as regards virus illnesses during pregnancy, bleeding, conditions during labor and delivery, and birth weight. The neonatal and infancy period are explored for illnesses, behavior, trauma, and developmental milestones. The childhood diseases and other illnesses are recorded as to age of onset. Interviews with parents and child are shaped to explore specific interpersonal dynamics and stresses, as well as affording an over-all assessment.

Careful attention should be paid to all reports by school personnel, especially the classroom teacher who has the opportunity of observing his learning ability, handling of material, and reaction under conditions of stress. Often, these children are able to cope with their environment until the prearranged routine of the school curriculum with its many demands makes the symptoms more obvious. When they start school, there is a

* Read May 17, 1965 at Atlantic City before Sections on Obstetrics and Gynecology, Pediatrics, Psychiatry and Neurology of The Medical Society of New Jersey.

comparison with other children of the same age, often for the first time, on a day by day basis, in a standard frame of reference by which performance can be judged. For these reasons, many requests for evaluation of a child are brought to the physician's attention with the primary complaint of either learning or behavior problems in the school setting.

Not every child with brain damage will show the demonstrable behavioral impairment associated with the syndrome. Each child has his own particular group of symptoms.

Experimental ablation studies[2] on infant animals indicate that early brain damage may result in very little or no specific behavioral deficit. Such a deficit, when it does appear, is less severe than that caused by a comparable lesion in adult animals.

Typically, hyperactivity is an outstanding and arresting symptom. It is an exaggerated response to stimuli in the environment. These children are usually in constant motion, touching objects and frequently destroying them. Occasionally hypokinesis may be seen. Silver[3] believes that this is most frequently found in children with developmental deviations or lag, rather than cerebral injury.

Impulsive acts (without thought of the consequences, despite previous "punishment" for similar activity) frequently lead to lying, stealing, setting fires, or destroying property. These children are frequently misdiagnosed as emotional problems or delinquents, when actually they are beset by learning problems. Frequently, their mothers and fathers are considered "bad" parents and have tremendous feelings of guilt associated with this problem and their inability to handle it adequately. Compulsive and rigid behavior are often seen as a result of the pressures upon the child and his attempts at control of his impulses.

A perseverating idea must run its course before the child can accept a new idea or undertake a new activity. It is hard for him to shift from one aspect of a situation to another, or to handle complex or multiple tasks. These children are easily distracted and their attention span is short. They have difficulty in distinguishing essentials from non-essentials, and in separating the parts from the background. The child has difficulty in inhibiting his impulses, and he is distracted by a multitude of simultaneous stimuli so that he is unable to inhibit insignificant details. This leads to confusion, disorganized thinking, and unclear communications.

Because of the great expenditure of energy accompanying the brain injured child's activities, he is susceptible to fatigue. He starts to work well, but often become disorganized and slovenly as the activity proceeds. Frustration tolerance is diminished, and minimal difficulties or any unfamiliar situation lead to the release of overwhelming anxiety. This is augmented by inability to compete, frequent failure, problems involving coordination, perceptual defects, difficulties in maintaining equilibrium and tonus, and by recognition of his own inadequacy. The mounting anxiety leads to withdrawal or to clinging, dependent behavior.

Brain damaged children show a puzzling and exasperating inconsistency in behavior. Memory is unpredictable. Learning seems rapid one day and difficult the next day.

The ability to deal with abstractions, to generalize and form concepts is impaired. So is skill in organizing and integrating. Performance in mathematics is particularly likely to be poor, since symbols seem to mean very little to these children. There may also be difficulty in the use of words as symbols for meaning, so that reading,[4] too, is a problem. Perceptual defects also play a large role in the difficulty these children have with mathematics and reading.

The ability to reproduce visual stimuli (like geometric designs) is impaired. These children are confused about spatial relationships. They have particular difficulty in the combination of parts into a whole.

In general, the pediatrician or neurologist

may find no abnormal findings in these children on routine physical and neurologic examination. More often, however, by using more specialized technics, certain abnormalities may be elicited. Thus, the examiner who knows what to look for may find aberations in the area of right-left determination. Many children have mixed laterality (hand, foot, or eye) or confused laterality (inability to distinguish right from left). Children with brain damage may show primitive postural reflex patterns.

Gait is often awkward, with difficulty in controlling balance. Clumsiness may be noted in the use of the hands, especially in holding a crayon or pencil or in catching a ball. There may be evidence of poor coordination between talking and respiration. These children are usually unable simultaneously to execute a requested motion with one hand while performing a different task with the other. The examination for nystagmus and extraocular incoordination should be given with scrupulous care, since the deviation is frequently fleeting and not obvious, unless watched for.

Language disturbances are frequently present. These children tend to have difficulty discriminating similar sounds or words, and show many sound substitutions. They have particular difficulty with final consonants and often omit them. Construction is simplified, with prepositions and articles omitted. There may be evidence of specific reading disability, with transposing of letters and words, and mirror reading.

An abnormal electroencephalogram may show localizing signs, a seizure pattern, or just a general dysrhythmia. A normal electroencephalogram does not rule out this diagnosis.

On psychologic evaluation, perceptual defects are seen in tests of spatial orientation (foreground *versus* background), and visual and auditory memory. There usually is poor performance on tasks closely related to neurologic maturation.

The average child scribbles at two years, draws a circle at three, copies a square at four, a triangle at five or six, and a diamond at seven years. There is a marked discrepency between these averages and the performance scores of children with cerebral damage.

The complete Wechsler Intelligence Scale for Children (WISC) should be administered routinely. The most common pattern[5] is scatter in either or both the Verbal and Performance Scales. Low scores most frequently occur in Arithmetic and Digit Span in the Verbal Scale, and Block Design, Object Assembly, Coding, and Mazes in the Performance Scale. The second most frequent WISC pattern is that in which the Verbal I.Q. is 15 to 40 points higher than the Performance I.Q.

The Bender Visual Motor Gestalt test measures perception and visual-motor coordination. The over-all "organic" reproductions are striking when compared with the norms provided.

The brain injured child usually draws a figure for the Draw-A-Person test which is immature in type, often with over-emphasis on the head. His inability to integrate the perception of himself into an adequate body image is evident.

To assist these youngsters in making good use of available resources, it is sometimes necessary to combine drug therapy with the other forms of therapy and counselling. Of the newer drugs, Thioridazine hydrochloride (Mellaril®) and the old standby amphetamines have been found to be effective in helping reduce hyperactivity and increase the attention span. Since each child responds differently to different drugs and dosages, adjustments should be made in both until the drug and dose are regulated to the individual child's needs.

How about diagnosis? It must be remembered that no single test is definitive for this disorder. Diagnosis is based on a variety of tests and technics which involve not only the child but his environment and his interaction with it as well. In the diagnosis of so highly

non-specific an entity, with so many subtle manifestations, a great deal of weight must be given to clinical judgment as well as to objective findings. One clinician (preferably the family physician or pediatrician who has had prolonged contact with the child and his parents) must be in charge of the case. He must assume responsibility for the final diagnosis after considering all findings made available by a multi-discipline diagnostic approach. And there must be a great deal of cooperation and communication among the physicians, patient, parents, psychologist, social worker, school personnel, and educators if the brain-damaged child is to receive the maximum benefit from the facilities, therapy, and support now available to him.

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213 River Road

New Federal Assistance in Health Education

The Health Professions Educational Assistance Amendments of 1965 (Public Law 89-290) have opened the way for accelerated action to overcome the shortage of professional health manpower. These amendments authorize increased appropriations for the student loan program and for federal grants to help build or expand schools of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry, and public health.

Students of osteopathy, pharmacy, and podiatry are now eligible for loans as a result of the amendments. The maximum individual loan has been increased from $2,000 per year to $2,500.

Provision was also made for cancellation of up to 50 percent of the total amount of loans and accrued interest for those physicians, dentists, and optometrists who practice in areas determined to have shortages.

The amendments also make provision for scholarship grants to schools of medicine, osteopathy, dentistry, optometry, podiatry, and pharmacy. These grants will be awarded to students from low-income families who without such financial assistance could not pursue a course of study. Scholarships may not exceed $2,500 a year.

Grant recipients to date include 21 medical schools which will be able to provide additional first year places for 750 students; 12 dental schools, 372 students; 4 schools of public health, 226 students; 16 schools of nursing, 786 students; 2 schools of optometry, 36 students; and 3 schools of pharmacy, 137 students. The two teaching hospitals are affiliated with schools of medicine.

So far as is known, this is the first case of Marchiafava-Bignami Disease reported in New Jersey.

Marchiafava-Bignami Disease*

Harold S. Feldman, M.D., Ph.D.
Livingston

A rare syndrome—primary degeneration of the corpus callosum (also known as callosal demyelinating encephalopathy) — or Marchiafava-Bignami disease was first described in 1903 by Marchiafava and Bignami.[1] To date, fewer than 60 cases have been reported in all the world literature. All patients have been males ranging in age from 39 to 82 years. Always, the patient was either a heavy drinker of crude red wine or unusually susceptible to the influence of alcohol. Most subjects have also exhibited varying degrees of the kind of malnutrition usually seen in chronic alcoholics.

A constitutional factor manifested in the form of racial distribution is strikingly evident. With three exceptions, all patients have been native Italians or of Italian ancestry. Of the exceptions, one American was addicted to crude red Italian wine[2] and two were chronic alcoholics of northern European ancestry, using a variety of liquors.[3, 4] It has been theorized that racial, nutritional and even social elements may be involved, as, for example, the custom in central and southern Italy of giving wine to very young children. Alcohol given during this important growth period may well act with special selectivity on the median layer of fibers of the corpus callosum which become myelinated later than the upper and lower layers.[5]

Bohrod[3] reports a "constitutional liability of the Italian male corpus callosum to alcohol when coupled with vitamin deficiencies." The lesions described in man were reproduced by the long-continued injection of sublethal doses of potassium cyanide into cats, but not into rabbits. The species specificity following the use of the same chemical substance suggests a constitutional factor in determining the reaction to a drug or to a vitamin deficiency.

There is a striking histologic resemblance between Marchiafava's disease and peripheral polyneuritis. This suggests the possibility of degenerative changes due to vitamin deficiency secondary to chronic alcoholic intoxication rather than a direct action of alcohol on the nerve fibers.[3, 5] A relationship between edema and Marchiafava's disease has also been considered, based on pathologic findings.[6]

An insidious onset, initial symptomatology so nonspecific that early manifestations may escape notice, and a tendency to remission and exacerbation in both somatic and psychic spheres, make it difficult to measure accurately the duration of the illness.

Clinical symptomatology contains elements of many better known pathologic states, particularly of chronic alcoholic deterioration with the general effect of delirium tremens.[5] Dominant features are: a marked and abnormal excitability, peculiar disposition toward wrath and acts of violence, sexual perversions, progressive mental decadence until mental con-

* From the Essex County Overbrook Hospital, Cedar Grove, New Jersey.

fusion and finally dementia set in. Almost constant are the physical disturbances consisting of: epileptiform and apoplectiform attacks, transient hemiparesis, clonic-tonic convulsions generally followed by a rise in body temperature, tremors, disturbances in speech, vertigo, frequent fainting, sudden and transient weakness of the lower limbs and ataxia. Often, however, patients are able to carry on their normal life routine up to the final phase of the disease. Usually beginning with an epileptiform attack, this phase is characterized by malnutrition, increased weakness of the lower limbs, stupor, and finally coma terminating in death.

The *sine qua non* of Marchiafava's disease is the prime pathologic finding: necrosis of the medial zone of the corpus callosum. This varies from softening and discoloration to cavitation and cyst formation—all stages of degeneration usually found in any given case. Generally, the rostral portion of the corpus callosum is affected first, the more caudal regions later. In addition, lesions of the anterior commissure, centrum semiovale, subcortical white matter, long association bundles, and middle cerebellar peduncles are not uncommon. The gray matter, internal capsule, corona radiata, and subgyral arcuate were never affected in any reported case at autopsy. The lesions begin as foci around the smaller radicles of the vascular tree and extend, becoming confluent and suggesting a relationship to the vascular system. It has been postulated that the responsible agent is "some abnormality in exchange between the contents of the blood stream and the tissues."[7]

Microscopically, the chief features are proliferation and fibrosis of the blood vessels within the lesions, slight lymphocytoid infiltration in the perivascular spaces, and fat-filled phagocytes; however, no evidence of inflammation has been found. All lesions have a constant bilateral symmetry and are manifested by a sharply defined necrotic process of demyelinization of nerve fibers with relative retention of the axis cylinders. Capillary endothelial proliferation may occur in the necrotic area but thrombi have not been noted in the blood vessels.[8]

The following is a case history of a patient presenting many of the clinical symptoms of Marchiafava's disease.

A married 53-year-old white male was first seen at Overbrook Hospital on September 11, 1964 because of convulsive seizures associated with bizarre overactive behavior. One of three siblings born of Italian ancestry, he denied any familial history of mental or physical illness. In childhood, he had had a severe blow on the head with a rock at the age of 5 and "rheumatism of the bones," persisting for a month at the age of 7. There were no visible residual effects (other than a small scar) from either incident. Married at 24, there was no knowledge of sexual deviation or venereal disease. Malnutrition occurred during military service, but the patient recovered as a prisoner of the U.S. occupation forces. He describes himself as "normal," friendly, without enemies, and not a "trouble-seeker."

The present illness began in 1946 at the age of 33 when a convulsion followed a particularly heavy drinking spree. The patient was a constant drinker. He told us he had been using wine since he was five years old! He was advised to stop drinking and smoking, and placed on anticonvulsant therapy. Refusing to change his habits or take medication regularly, he continued to have seizures at 5 to 6-month intervals. Several days prior to hospitalization, the patient became delusional, imagining that his wife was unfaithful. He began to break things about the house and exhibit generally bizarre uncontrollable behavior for the first time.

Examination on admission revealed a confused, well-developed man, tidy and cooperative. Shortly after entering the ward, the patient became violent and was placed in seclusion. Medication consisted of diphenylhydantoin and phenobarbital. Laboratory studies were within normal limits. Chest x-rays, skull films, and pneumonencephalogram were negative. Electroencephalography revealed abnormal spikes with dysrhythmia in the right occipital lobe area suggestive of an irritating lesion.

The patient has remained seizure-free and cooperative while on medication. However, because of the etiology, racial distribution, slow progression, and lack of positive diagnoss until necropsy, Marchiafava's disease is considered to be the working diagnosis.

Summary

A brief review of the clinical and pathological symptoms of Marchiafava's disease and a report of a suspected case is presented as an aid for the physician treating chronic alcoholics manifesting psychotic behavior and organic brain disease. The inclusion of this syndrome in the differential diagnosis of this type of patient is strongly advised, although definite diagnosis can only be confirmed by necropsy.

Chief pathologic findings are medial necrosis or degeneration of the corpus collosum with

demyelination of the phagocytic glia cells and fibrosis of the blood vessels. Clinical features include marked excitability and violence, progressive mental decadence, and confusion together with epileptiform attacks, weakness, and ataxia. As in other degenerative processes, a constitutional factor such as racial distribution might be of considerable importance in the elective localization of the degenerative process in a particular site, namely the corpus callosum. Final diagnosis on the patient presented must await further observation.

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Massive venous occlusion, an uncommon but harrowing disorder, may respond—as this one did—to conservative treatment.

Phlegmasia Cerulea Dolens*

The Conservative Approach

John L. Costello, M.D./Jersey City

Phlegmasia cerulea dolens, more properly termed "acute massive venous occlusion," is not a common condition. Its seriousness, however, and the grave prognosis in regard to the loss of limbs and lives prompt further consideration of this disorder.

This very serious form of thrombophlebitis presents itself with massive venous engorgement and deep violet discoloration of the extremity. Arterial insufficiency is a nearly constant finding. As it progresses, the arteriospasm may become severe enough to produce gangrene. Actual mechanical obstruction of blood flow because of massive thrombosis may cause nearly complete arrest of the capillary blood flow.[7] The marked rise of capillary filtration due to the high capillary pressure leads to the development of massive edema, and the loss of a large amount of fluid into the tissue of the limb may lead to oligemic shock.

Excellent reviews of the literature have been prepared by Ochsner and DeBakey,[6] Haimovici,[5] Anlyan and Hart,[11] Veal[7] and more recently by Boyd and Clarke.[8]

Etiology

Acute or chronic phlebitis frequently precedes the more serious form. It is often associated with neoplastic disease especially in the pelvis (as in our case presentation), or neoplasm elsewhere in the body. It may be associated with ulcerative colitis, following pelvic surgery, or it may occur in an apparently healthy individual. Both sexes are about equally affected and may be seen in any age group.

Signs And Symptoms

Pain is usually the first symptom. The onset (generally sudden and severe) is in the upper thigh and rapidly progresses downward. The lower extremity then takes on a dusky, cyanotic appearance. Discoloration develops rapidly and extends distally involving the entire extremity. Edema soon develops and progresses rapidly. It may extend beyond the groin into the buttocks and up to the abdominal wall with the skin becoming tensed, glossy, and of a woody consistency. The superficial veins become distended and are grossly visible over the buttocks and abdominal wall. The pulse rate rises and the pressure drops because of loss of circulatory volume as the congestion progresses.

Attempts at movement of the leg are excruciatingly painful. Raising the limb does not affect the color or the degree of venous filling. Peripheral pulses may be present initially, but because of excessive edema of the extremity, peripheral circulatory failure, or arteriospasm, they are not palpable for very long. Oscillometric studies are painful and possibly could dislodge a clot. Subsequent phlebitis of the other limb may occur,[6] especially when the thrombus extends to the common iliac veins. This complication

* Read at the Centennial Surgical Institute of St. Francis Hospital in Jersey City.

is clearly demonstrated in the case cited below. Usually the disease is progressive with the development of moist gangrene of the distal parts of the extremity. Blebs, blisters, and lymphangitis may complicate matters. In the beginning the line of demarcation is not clearly defined. A feature to be borne in mind is that in the majority of cases, the gangrene remains superficial.

Diagnosis

The disorder must be differentiated from acute ischemia of arterial origin. The cool, white leg without edema, with numbness and a progressively waxy appearance, and the diminution or loss of pulsations in the leg aid in differentiating this from arterial occlusion.

Case Report

A nulliparous, 37 year-old-female was admitted to our hospital in May 1957. She had enjoyed good health until six weeks prior to admission. She complained of fatigue and lethargy, and had an episode of thrombophlebitis in the right lower extremity. She recovered from this, and was well up until the day before admission when she noticed swelling and tenderness in the left calf. She also complained of tenderness in the right lower quadrant. She was treated in the routine fashion and did well until 17 days after admission, when she developed a classical picture of massive occlusion of the right lower extremity. She was placed on anticoagulants, elevation of the extremity, elastic bandages, and analgesics. One week later, she developed severe left pleuritic pain with dullness in the base of the left lung. The right lower extremity became massive with edema, congestion, and discoloration. The left leg looked normal. It was felt that pulmonary embolus accounted for the chest pain. The toes and foot became bluish-black and the entire leg was mottled and cyanotic. No pulsations were felt. Paravertebral block was done with some relief of pain, and a slight warmth to the leg ensued. Her temperature rose to 102. Seven days later, she developed the same condition in the left leg even though antibiotics and anticoagulants were being continued. Paravertebral block was then instituted on the left. This gave some relief of pain.

The edema now involved both extremities and extended into the back, abdominal wall, and cephalad as far as the breasts. The toes of both extremities exhibited gangrenous changes as well as the bottom of the soles. This last episode occurred six weeks following the initial admission. Diuretics helped to relieve the edema. Bone marrow studies and x-rays of the long bones were negative. Local treatment, plus debridement, was instituted to the feet and toes, and demarcation set in by August 23. Gradually the edema lessened, and active and passive exercises were instituted.

Because of the extensive body edema, adequate abdominal and pelvic examinations were impossible. On September 22 the situation had subsided to the point where a proper gynecologic examination could be made. There was noted a football-sized mass occupying the pelvis. This was thought to be a huge fibroid uterus or a large carcinoma of the right ovary. Pyelogram showed hydronephrosis of the right kidney with ureteral dilatation and kinking of the distal right ureter. She was discharged on October 15 and readmitted a month later for a 12-day stay. During this period, the terminal phalanges of the second right toe and the second, third, fourth, and fifth left toes were amputated. She was re-admitted six weeks later and a panhysterectomy was done. A huge carcinoma of the right ovary was noted. Recovery was without incident.

The patient was treated with deep x-ray therapy following her last hospital discharge. We have had the good fortune to see this patient every six months since discharge for the past seven years. She has some residual thickening of the legs, but they are nearly normal in appearance now. She is restricted to a low salt diet and takes 500 milligrams of Diuril® daily. She lives a perfectly normal life. There is no evidence of any neoplastic recurrence.

Summary

A review of the literature and our own experience indicates that phlegmasia cerulea dolens is a dangerous disease which may be complicated by shock and gangrene. It may be confused with obstruction of the arterial tree. The mortality rate of phlegmasia cerulea dolens is high, but the results are influenced by early recognition and the immediate treatment with antispasmodic drugs, nerve blocks, and anticoagulation therapy. Some[9] feel that fasciotomy to relieve the edema may be helpful. Others[8] suggest inter-arterial antispasmodics and thrombectomy. We have treated our cases conservatively.

Ligation of the inferior vena cava was considered because of the pulmonary embolus, but it was felt that we might propagate more emboli. We have had no experience with thrombectomy, but recognize that it could be an important adjunct in the treatment of massive venous occlusion.

This interesting case of phlegmasia cerulea dolens involved both lower extremities with edema to the nipple line caused by a pelvic neoplasm. She survived this harrowing ordeal and the subsequent surgery, and enjoys excellent health at this writing, seven years later.

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2615 Boulevard

Social Security Disability Reports

When you send in medical reports to the Social Security program, you are now asked to report by means of a familiar medical narrative rather than a questionnaire. If the report lacks sufficient information for a disability determination, the reviewing M.D. may phone you for additional data that you may have in your own records. If you haven't the information he needs, he may ask you to re-examine or do additional tests at a scheduled fee.

Jarvis M. Smith, M.D., the recently appointed Medical Director of the Rehabilitation Commission, explained the new plan to a JOURNAL representative this way:

"Generally, the treating physician can provide all the medical evidence we need for determining whether the patient is disabled. Now we hope to benefit more than ever from the physician's resources while best suiting his convenience."

"Actually," continued Dr. Smith, "it was the expressed preference of medical practitioners which led to our abandoning the old questionnaire form in favor of the more familiar narrative. And this was actually tested. In six states, we prepared a sort of controlled experiment, and in all six we found that doctors could give a clearer, more complete clinical picture of a claimant by using a reporting format that comes as second nature to most physicians. As a result, the disability program has just introduced a revised form designed to provide ample space and a more effective format for detailing the patient's history, physical and laboratory findings."

"This format and space will help you transcribe those parts of the patient's chart pertinent to his impairment," added Dr. Smith. "When you report the data that our reviewing M.D. needs to evaluate remaining capacity for work, you're helping your patient receive swift and medically sound handling of his claim."

If additional data is needed for an evaluation, the reviewing doctor may call you. And if (as usually happens) the information he needs is available in your records, it can be given over the phone. Otherwise, he may invite you to obtain it for a fee that has been established in conjunction with The Medical Society of New Jersey. "Experience shows that our phone calls generally take under five minutes. In states where this has been tested, reporting doctors volunteered the opinion that they prefer such calls to letters of inquiry. Also, doctors said, they welcome the chance to discuss the case with colleagues at the disability agency."

In this short monograph, the author offers a practical guide to the recognition and management of ulcerative bleeding from the large bowel.

Treatment Of Bleeding In Ulcerative Disease Of The Large Bowel*

Abraham I. Friedman, M.D./Hackensack

If we were to estimate the frequency of bleeding in carcinoma of colonic lesions and compare this with its frequency in other conditions in this table (Table 1), I think we would find that the ratio is about 3 to 2 in favor of benign ulcerations. This might vary with the doctor's type of practice, but general statistical data (including gastroenterologic, proctologic, and surgical experience) would show, I believe, that relationship. One must emphasize, however, that colon carcinoma has become the number one cancer in frequency in the adult population of the United States; consequently, this ratio may be changing[1]. This chart reveals 51 instances of colonic bleeding seen in the last four years with certain exclusions.† They have been divided into two categories: the massive bleeding (or M) and those with less massive bleeding. In the M group, the hematocrit is generally below 25 and the hemoglobin is under 8. These patients require repeated transfusions to maintain blood levels above these figures

I have divided ulcerative colitis into two groups: universal and localized. The latter refers to lesions localized to the rectum. Although the frequency of bleeding in localized disease of the rectum is higher, the severity is greater in "universal" colitis. All chronic ulcerative colitis at one time or another will bleed.

It is important *not* to subject severely ill colitis patients to vigorous investigation. Barium enemas and even sigmoidoscopies should be performed cautiously or avoided in the seriously ill patient. Any procedure which irritates the bowel (glucose tolerance tests, for example may do so) will provoke more profuse bleeding. Ulcerative colitis in an adult in the second and third decades will bleed more frequently and severely than in the child.

TABLE 1

BLEEDING IN ULCERATIVE DISEASE OF THE COLON

		(M)
1. Non-specific Ulcerative Colitis	32	(4) *
(a) Rectal	10	(0)
(b) Universal	22	(4) *
2. Granulomatous Ulcerative Colitis	7	(0)
3. Diverticulitis	6	(2) *
4. Dysentery	1	
5. Radiation Bowel Injury	2	
6. Amebic Colitis	1	
7. Endometriosis	1	
8. Lymphogranuloma Venereum	1	

* M = Massive Hemorrhage frequency is indicated by figures in parenthesis.

The color of the stool in the patient who is bleeding severely presents an interesting contrast. It is usually venous blood and looks like thin, dark beet soup mixed with white blobs of pus and very little or no stool. In the occasional patient there is liquid blood and formed stool. In the acute hemorrhagic patient there is profuse oozing requiring two to four units of blood a day. On sigmoidoscopy, the colon is succulent and engorged and looks like clotted blood or fresh beef liver.

* Read May 18, 1965 at the Annual Meeting of The Medical Society of New Jersey, this work comes from the Department of Gastro-enterology at the Bergen Pines Hospital in Paramus, N.J.

† Excluded from the survey: ulcerating carcinoma, adenoma, and internal hemorrhoids.

The treatment of massive bleeding in ulcerative colitis (Table 2) includes blood replacement, transfusions, fresh frozen antihemophiliac plasma (if obtainable), or liquid plasma, volume replacement, electrolytes, and evaluation and control of coagulation factors including fibrinogen, Vitamin K_1, multivitamins, adrenocorticotrophic hormone (intravenously or intramuscularly, preferably the former) corticosteroids, parenterally and intravenously, a low residue diet as tolerated, and as a final resort, surgery. Steroids represent the most important addition to our treatment regime. We have not found that steroids in the acutely ill patient (e.g., toxic megacolon) adversely affect the colon. We have seen thinning, friability, and disintegration of the colon before steroids were ever employed. It is caused by profound necrosis of the mucosa, submucosa, and muscularis. Bleeding is *not* a contraindication. As a matter of fact, massive hemorrhage has been controlled during treatment with corticosteroids in two of our patients. One patient in whom this approach was twice successful was a member of Jehovah's Witnesses in whom blood and blood substitutes could not be administered because of her religious convictions. The hemoglobin dropped to 5 Grams and remained there for several weeks before it finally improved with resolution of the disease. During this time we used an iron dextran injection tradenamed as Imferon® (Lakeside) as well as other preparation of iron as tolerated, plus Dextran intravenously to maintain blood volume. Rarely have we seen adrenocorticosteroids or corticotrophic hormones manifest unusual complications when given in ulcerative colitis. Only one adolescent female developed osteoporosis of a vertebra; and here the effect of other medications on bone metabolism was raised. Topical, local, and intrarectal medications (while useful in the chronic or subacute phases of the disease) rarely are helpful in the acute hemorrhagic type of ulcerative colitis because of colon irritability. Six-Mercaptopurine® was used in two patients, in 50-milligram per day dose. In both there was a flare-up of significant bleeding and recurrence of friable, granulating mucosa, although prior to the use of this medication bleeding was minimal. In general, it is our custom empirically to employ one unit of plasma for each three or four units of blood in order to overcome the loss of accessory factors. Surgery should be done before the blood clotting factors are irreversibly affected following multiple transfusions and, of course, before the patient becomes moribund. Surgical intervention, while a last resort, usually is successful if the patient's nutrition and general status have been maintained by means of steroid therapy.

TABLE 2

TREATMENT OF BLEEDING IN ULCERATIVE COLITIS

1. Blood and fluid replacement
   (a) Transfusions—24 hours
   (b) Plasma (frozen or fresh)
   (c) Electrolytes, Dextran
   (d) Coagulation factors, fibrinogens, vitamin K_1, multivitamins
2. Steroids
   (a) ACTH—intrav., intram., 200 to 300 units
   (b) Corticosteroids, (Prednisone, Triamcinolone,® Medrol®) 30 to 60 mg. a day, parentally, orally, rectally.
3. Antibiotics (fever-blanket)
4. Liquid diet—as tolerated
5. Symptomatic—codeine, meperidine.
6. Surgery

Granulomatous colitis usually affects the right colon with small bowel disease, but it may involve the left or any segment of the colon. It is difficult to prove this pathologically because, in the end stage, granulomas are destroyed and replaced by fibrous tissue. It is only in early phases that one can, with any certainty, state that the disease is nonspecific, inflammatory, chronic ulcerative colitis or granulomatous disease, Crohn's disease.

Clinically and radiologically the diagnosis can be made because fistulization, skip areas, local stricturing and involvement of the small bowel all represent features of Crohn's disease.[2] Bleeding is rarely severe. It is generally controlled without significant intervention, particularly with the use of steroids. It is likely that the frequency of granulomatous disease will rise substantially as we appreciate these features and realize that many patients diag-

nosed as ulcerative colitis suffer from granulomatous disease of the colon.

We have seen only one patient with amebic colitis and significant bleeding. On sigmoidoscopy, the examiner sees the typical isolated ulcers, one to three centimeters apart. The mucosa between them appears completely normal. The margins of the ulcers are sharp and clearcut, although on occasion (because of secondary infection) this picture of intervening normal tissue disappears behind a barrier of chronic infection. Bleeding in amebiasis is usually a result of ulceration and erosion of a blood vessel. Table 3 summarizes the therapy[3] of amebic colitis.

TABLE 3

TREATMENT OF BLEEDING IN AMEBIASIS

1. Diodoquin .650 gm. tid a.c. for 21 days
2. Chloroquine diphosphate .5 gm. for 14 days
3. Tetracycline 0.250 gm qid for 4 days
4. Emetine 0.030 gm. (Subcut.) bid for 7 days
5. Symptomatic (Codeine), etc.
6. Fluids, intravenously

Colonic diverticuli have an 8 per cent frequency of bleeding in our series; in over 50 patients with diverticulosis, four were bleeding from diverticula. Hemorrhage is caused by ulceration in association with diverticulosis and/or diverticulitis. Bleeding is more likely after the inflammatory process has subsided with the invasion of new blood vessels. Obviously it is important to exclude other sources of bleeding. The diagnosis may be difficult because in many instances of diverticulitis, diverticula are not easily visualized by x-ray. Although diverticula are present in elderly patients, one cannot assume that the physiologically aged and arteriosclerotic blood vessels are the cause of bleeding. Noer[4] has shown the remarkable concentration of blood vessels that exist in the region of colonic diverticula.

It is unusual to see the openings of diverticula during sigmoidoscopy and certainly unusual to see them bleed. We saw one patient with a massive exsanguinating hemorrhage from an ulceration into an artery in a diverticulum and who died before surgery could be performed. We have seen at least five instances of diverticulosis in association with carcinoma. This is simply a random association. It is usually difficult during a barium enema or a sigmoidoscopic examination to establish the diagnosis unless a specific filling defect is seen. Treatment in general is supportive; if patients bleed frequently from diverticula, surgery will be necessary. However, the inflammatory area is often difficult to resect because of profuse oozing that occurs at surgery. Some patients may be left with a permanent colostomy.

In endometriosis, the colon and rectum may be implanted with ectopic endometrial tissue presenting a histologic structure identical to that of uterine mucosa[5]. Glands and cysts are likely to form and may fill with menstural blood. On sigmoidoscopy a purplish-blue area may be seen during menstruation. There is superficial ulceration if bleeding is present. In our case the surrounding area was somewhat edematous and bled easily on contact. Significant bleeding was not seen. Despite the possibility of the development of secondary male sexual characteristics, one may be able to control the condition with androgens. In one patient, because of the associated menstrual pain, hysterectomy and radiation were followed by complete relief and atresia of the endometrial implant.

Radiation colitis was seen in two patients. One man of 54 had received cobalt therapy for a bone lesion in the left hip. Eight months later, he had rectal bleeding. Sigmoidoscopy revealed a thickened, indurated rectal wall and a grayish ulcer with prominent telangiectasia in the sigmoid colon. The latter are considered pathognomonic. It was assumed that, because of telangiectasia, the time interval between the roentgen therapy and bleeding was radiation colitis rather than extension of the original lesion. Another patient with carcinoma of the cervix received radium therapy as well as cobalt. In her, a constricting ulcerative lesion was seen. Bleeding was never massive in either case. Both had severe rectal tenesmus in addition to the moderate bleeding. Hemorrhage was controlled by cauterization, packing, and steroids. The frequency of

radiation enterocolitis appears to be increasing.[6]

Lymphogranuloma venereum was seen in one patient. The characteristic lesion occurs in the rectum in females. The difference in the site of the lesion is due to the location of the primary focus. In the male, the lymphatics drain from the anterior urethra to produce buboes in the inguinal area. In the female, the virus is implanted along the posterior wall of the vagina or the lip of the cervix and passes through the lateral rectal wall. Benign rectal stricture without previous surgery is considered to be pathognomonic of lymphogranuloma venereum. An early symptom is persistent rectal bleeding.[7] As the disease progresses, pain and finally stricture develop with obstructive manifestations. In this patient it was impossible to pass anything except an infant sigmoidoscope into the rectal area. It revealed a granular, intensely injected mucosa that bled profusely. This patient was treated with antibiotics and steroids, and the bleeding was controlled. The tubular stricturing improved.

Conclusions

The most frequent cause of significant colonic bleeding in non-malignant ulcerative disease is non-specific ulcerative colitis. Although bleeding occurs in almost all patients with ulcerative colitis, severe bleeding is present in 12 to 15 per cent. A third of these will require surgery for the control of the bleeding. Steroids should be vigorously used when necessary. Granulomatous colitis is rarely associated with massive bleeding, although about 20 per cent will bleed initially. Bleeding from diverticulosis or diverticulitis of the colon has been seen in 8 per cent of the patients. Carcinoma of the colon must be excluded. Surgery in severe diverticulitis with bleeding may be difficult; rarely is necessary, but occasionally is life-saving. Bleeding in radiation colitis appears to be increasing in frequency. Treatment of all of the above conditions is primarily medical.

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405 State Street

Air Pollution and Respiratory Disease

A study* of 1,261 residents in New Hampshire measured amount of respiratory disease symptoms in relation to three residential areas of varying air pollution and in association with amount of smoking. The data confirmed previous observations that cigarette smoking was a more significant factor than air pollution.

One area had more than double the pollution of dustfall and sulphur dioxide than the other two areas, yet no significant differences were found among the three areas for all respiratory disease, chronic bronchitis, or obstructive lung disease for either males or females. Among non-smokers the only statistical relationship between disease and area of pollution was for females with chronic bronchitis. Among heavy cigarette smokers (21 to 40 cigarettes a day) no significant effect of the residential variable was noted.

* *Levels of Air Pollution and Respiratory Disease in Berlin, New Hampshire*. Anderson, D. O., Ferris, B. G. Jr., and Zickmantel, R. Amer. Rev. Resp. Dis. 90:877 (1964)

Arthrography is shown here to be a safe and reliable diagnostic procedure that should be tried before arthrotomy is undertaken.

Arthrography In The Diagnosis Of Joint Disease

Marvin Chirls, M.D./East Orange

Arthrography was first described in 1905 by Werndorff and Robinson,[1] who used oxygen as the contrast medium to demonstrate the internal structures of the knee. During the next few years, studies were reported by Wollenberg[2] and Hoffa[3], and Rauenback[4] described his first attempts at pneumoarthrography. Since then many arthrographic procedures have been reported both in Europe and in the United States. At the outset, interest was centered on finding suitable contrast media.[5] In addition to oxygen, a variety of substances[5] including air, carbon dioxide, iodized oils, and water soluble iodides were tried.[6] Later, it was realized that a suitable medium was not the only decisive factor in obtaining diagnostic contrast. Attention was then directed primarily to improvements in technic.

Although arthrography has been used extensively in Europe for several decades, it has not gained wide acceptance in the United States. Turner and Wurtz[8] have cited two reasons for this failure: difficulty in learning to interpret the films correctly and the time and expense involved in the examination. Reports on the accuracy of diagnosis by arthrography have varied widely. The correct diagnoses in different studies have ranged from 53 percent to nearly 100 percent of patients examined. Kessler and his coworkers[9] found an even wider variation in the reported rate of error in diagnosis by arthrography.

The wide divergence of opinions of different authors on the value of arthrography in the diagnosis of articular conditions led to our study of the procedure. A few investigators[10] have failed to obtain useful films for diagnosis.[11] Others[12] have found the procedure to have only limited value.[13,14] On the other hand, a number of investigators[7] have concluded that it is a valuable aid[15] in diagnosis of conditions affecting the knee,[16] shoulder,[17] or other joints.[18]

In this study our purpose was to discover whether arthrography was helpful and safe to use in the diagnosis of the articular conditions commonly encountered in daily orthopedic practice. Accordingly, we have used arthrography to study a wide variety of conditions affecting the knee, hip, shoulder and other joints. A brief account of our experience in the use of this procedure follows.

Patients

Forty-six patients were selected at random as subjects of this study. All these patients were seen in the course of regular daily practice. Their ages ranged from 6 months to 66 years and averaged 35. All presented evidence of conditions, traumatic or non-traumatic, affecting one or more joints. The knee was examined in 19 patients, the hip in 8, the shoulder in 9, the ankle in 4, the wrist in 2, the metatarsophalangeal joint in 2, and the elbow in one. The series also included a 2-year old patient whose right shoulder, right knee, and both hips were examined. All of these patients were checked by the author, and all were followed for periods of from 1 to 19 months after examination.

Contrast Agent

The contrast agent was a 60 per cent aqueous solution of methylglucamine diatrizoate (Renografin-60*). This radiopaque material has proved to be a satisfactory contrast medium in procedures such as aortography,[19] arteriography,[20] and urography,[21] as well as in arthrography of the hip.[18] In the latter procedure, Barnett and Arcomano[18] found that methylglucamine diatrizoate was "innocuous and kind to the tissues" and the medium of choice in hip arthrography in children.

Air was used in combination with methylglucamine diatrizoate in the examination of all knee joints. In all other examinations, the radiopaque material was the only contrast medium employed.

Procedure

Arthrography was done under general anesthesia in 7 patients of the series who were undergoing surgery or manipulations. The other 39 patients were examined under local anesthesia. The site of injection was first sterilized, and then either 1 per cent procaine or 1 per cent lidocaine was infiltrated into the skin through a 25-gauge needle. After the skin was anesthetized, a 20-gauge, 1½-inch needle was used to enter the joint. (In the knee examinations, entry was either above or below the patella.) After making certain that the needle was clear into the joint, the examination then proceeded in one of two ways. If air was to be used in the examination (as was the case in all knee joint examinations), first the air and then the radiopaque medium was injected. If only the dye was to be used, the joint was irrigated by saline solution before the injection of the radiopaque medium. The amount of methylglucamine diatrizoate used in the different joints varied according to their size and ranged from 0.5 in the metatarsophalangeal joint to 25 cubic centimeters in the knee joint. X-ray films were obtained within 20 minutes after injection of the contrast medium.

* Renografin® is a trademark of E. R. Squibb & Sons, New York, N.Y.

At the time of the examination, all patients were asked whether they had experienced any pain during the procedure. After the examination, all patients were observed carefully for local or systemic reactions.

Biopsy was obtained at surgery; or a needle biopsy was done 24 hours after arthrography in 10 patients. These included patients with: osteoarthritis (1), pigmented villonodular synovitis (1), posttraumatic arthritis (1), torn medial meniscus (3), torn lateral ligaments (2), dysplasia epiphysalis multiplex (1), and painful ankle (1).

Results

A total of 49 arthrographies was performed, and satisfactory contrast was generally obtained. The diagnoses are shown in the table. The following disorders were demonstrated by arthrography:

1. Torn medial meniscus
2. Pigmented villonodular synovitis
3. Calcification of the epiphysis in Perthes' disease
4. Structural abnormalities in congenitally dislocated hips
5. Torn ligaments in various joints
6. Coxa vara in dysplasia epiphysalis multiplex
7. Rotator cuff tears in the shoulder
8. Cartilagenous defects in intra-articular fractures.

Biopsy reports were consistent with the arthrographies in all of the 10 patients in whom biopsy was performed.

No patient of the series experienced an acute reaction to the injection of methylglucamine diatrizoate. Two complained of pain 24 hours after injection of the dye into the knee and hip joints, respectively. In both cases, extravasation of the radiopaque medium occurred at the time of the examination. No rise in temperature occurred, either in the hospitalized patients or in the outpatients. No skin reaction was observed in any case. No eosinophilia was found in the synovia or synovial fluid after examination in any of the patients.

Comment

Contrast arthrography is a diagnostic procedure that is as simple and easy to perform as

arthrocentesis. In our experience it has proved safe as a routine measure. With present day technics and methods of radiography, arthrography should become a part of established procedure in the diagnosis of joint lesions. Cartilaginous loose bodies in the joint (that are not visualized by the usual radiographic technics) can be demonstrated easily with arthrography. Neviaser and Eisenberg[22] have shown that ligamentous injuries may be demonstrated by allowing the dye to extravasate into the surrounding soft tissue masses, as one would in the demonstration of a tear in the rotator-cuff mechanism. We have found contrast arthrography of definite value in appraising the extent of ligamental tears in the knee and ankle. On the other hand, in our hands arthrography has *not* proved to be as useful in the diagnosis of injuries to the triangular ligament of the wrist, as Kessler and Silberman[23] found it to be. It has been our experience that, in this type of lesion, arthrography has often yielded false-positive results.

Because of the simplicity and safety of arthrography, we believe there are no contraindications to its use in the office.

Summary

1. Forty-nine joints in 46 patients had been examined by contrast arthrography, using a 60 per cent solution of methylglucamine diatrizoate as the contrast medium, with and without the concomitant use of air. The joints examined by this procedure included the knee (20), hip (10), shoulder (10), ankle (4), wrist (2), metatarsophalangeal joint (2), and elbow (1). Biopsy was performed at surgery, or a needle biopsy was obtained 24 hours after the examination in 10 patients. All patients were followed from 1 to 18 months after examination.

2. Satisfactory contrast was obtained in all 49 arthrographic studies.

3. Biopsy reports were consistent with the diagnoses in all of the ten patients in whom biopsy was done.

4. No acute reactions occurred. No elevation in temperature and no skin reactions were observed. No eosinophilia was found in the synovia or synovial fluid after examination in any of the patients. Two patients complained of pain 24 hours after injection of the radiopaque contrast medium into the knee and hip joints, respectively. In both cases, extravasation of the dye occurred at the time of the examination.

5. Arthrography, using a 60 per cent solution of methylglucamine diatrizoate, with or without the concomitant injection of air, is a safe and reliable diagnostic procedure that is as simple to perform as arthrocentesis. It should be used before arthrotomy is undertaken. Because of the simplicity and safety of the procedure, there are no contraindications to its use in the office.

JOINTS EXAMINED BY ARTHROGRAPHY USING 60 PER CENT METHYLGLUCAMINE DIATRIZOATE*

Diagnosis	No. of Joints
Torn Ligaments	7
Dysplasia Epiphysalis Multiplex	5‡
Arthritis	4
Torn Medial Meniscus	4
Bone Fracture	3
Periarthritis	3
Congenital Dislocation of the Hip	3
Baker's Cyst	2
Rotator-Cuff Injury	2
Painful Shoulder Syndrome	2
Chondromalacia of the Patella	2
Hallux Rigidus	2‡
Perthes' Disease	2
Osteoarthritis	1
Pigmented Villondodular Synovitis	1
Subluxation (Osteotomy)	1
Recurrent Dislocation of the Patella	1
Osteochondromatosis	1
Aseptic Necrosis	1
Synovitis (Rheumatoid)	1
Painful Ankle	1
TOTALS	49

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* Oxygen was used with methylglucamine diatrizoate in all examinations of the knee joint.

† Metatarsophalangeal joint.

‡ Including 1 patient in whom the hip was affected and 1 patient in whom the right shoulder, right knee, and both hips were affected.

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109 South Main Street

Uric Acid Balance

Studies of factors arising during fasting which could influence uric acid excretion were carried out in 15 patients. Potassium supplementation and alkalinization did *not* influence the decreased urinary excretion of uric acid found during fasting, whereas probenecid and glucose administration effected a prompt uricosuria. Glomerular filtration rate was not altered by seven days of fasting, but changes in uric acid balance appeared to be related to changes in ketone concentrations. The effect of ketosis in the absence of fasting was studied by feeding high fat diets in six subjects and ketone infusions in five others. In both groups uric acid clearance was depressed. It is postulated that ketones compete with uric acid for a common tubular secretory site.

—F. R. Lecoco, *Metabolism* 14:186 (Feb. 1965)

C.S.F. In Guillain-Barre Syndrone

Of 93 patients suffering from Guillain-Barré syndrome who had lumbar punctures, 89 had abnormal protein values, most frequently between 50 and 200, at some time during their illness. Certain patients who, early in the course of their illness, had normal values showed an elevation later; others showed an increase as the disease progressed. An elevation of cerebrospinal fluid protein and normal or slightly increased cell count are consistent findings if lumbar punctures are repeated, or if only one puncture is done at the height of the illness when protein is most likely to be elevated. Whenever lumbar punctures are repeated during the course of the illness, the protein determination should be made on the first specimen withdrawn, so that comparable values can be obtained.

—W. G. Wiederholt and D. W. Mulder, *Neurology* 15:184 (Feb. 1965)

STATE ACTIVITIES

Trustees' Minutes

December 19, 1965

A regular meeting of the Board of Trustees was held on Sunday, December 19, 1965, at the Executive Offices. Detailed minutes are on file with the Secretary of each component society. A summary of the significant actions follows.

Bicentennial History . . . Authorized publication of a 420-page history of MSNJ; set the sale price per copy at $10; directed that final overall cost of publication, mailing, and postage be subject to approval by the Bicentennial History Committee.

Liability Panel . . . Assigned to the Committee on Inter-Relations with the Judiciary and the Bar the task of selecting panel-physicians in connection with the establishment of the Professional Liability Panel (in cooperation with the Courts) to evaluate negligence claims.

AMA Dues' Increase . . . Directed that component societies be informed that, at the recent AMA Clinical Convention in Philadelphia, the New Jersey delegation recorded itself—in both the reference committee and in the House—as *disapproving* any action by the AMA House to indicate support of a membership dues' increase of $25, proposed for January 1, 1967; requested component societies who oppose the increase to protest directly to the AMA Board Trustees in Chicago.

Osteopathic Physicians in the Armed Forces . . . Endorsed the Camden County Medical Society's protest (to the Surgeon General) that osteopathic physicians have not yet been called to service in the Armed Forces; directed that the AMA be informed of this action and be requested to ask for the sharing of responsibility by osteopathic physicians to shoulder the burden of service in the U. S. Army or other service branches.

Headquarters' Property . . . Authorized Legal Counsel to oppose on behalf of MSNJ (because of increased traffic) the granting of a variance to permit the erection of a Holiday Inn Motel diagonally across the street from the Society's Headquarters.

Bicentennial Citation . . .Requested that the AMA Board of Trustees honor MSNJ in recognition of the bicentennial of its founding, in the form of a scroll, similar to that issued the University of Pennsylvania School of Medicine in recognition of its bicentennial.

Science Center . . .Designated Dr. Louis K. Collins of Glassboro as MSNJ's representative to the advisory group of the University City Science Center, for the preparation of a planning grant request to the National Institutes of Heart Disease, Cancer, and Stroke, Amendments of 1965.

Auxiliary President . . . Approved the request of MSNJ's Woman's Auxiliary that The Medical Society of New Jersey co-sponsor with it in Chicago at the AMA meeting in June 1966 a reception honoring Mrs. Asher Yaguda of Newark, who will be installed at the time as President of the AMA Woman's Auxiliary; authorized that the estimated cost be shared equally with the Auxiliary, up to $1,500.

JOURNAL Editor . . . Directed that a plaque be presented to Dr. Henry A. Davidson who, in June 1966, will have completed 25 years as Editor of the MSNJ JOURNAL; further directed that an appropriate issue of THE JOURNAL be dedicated to him.

Mental Health Conference . . . Authorized Dr. Robert S. Garber, Chairman of MSNJ's Mental Health Committee, to attend the 12th Conference of State Mental Health Representatives to be held in Chicago on March 18 and 19.

JOURNAL Cover . . . Approved the action of the Publication Committee in authorizing a new cover for THE JOURNAL in recognition of the Society's bicentennial celebration.

Committee on Honorary Membership . . . Approved the following nominations for honorary membership (as submitted by the committee)—and directed that they be transmitted to component societies, as required in the Constitution:

1. Morris Fishbein, M.D.—Nominated by Board of Trustees
2. Selman A. Waksman, Ph.D.—Nominated by Board of Trustees
3. Richard I. Nevin—Nominated by Hudson County Medical Society
4. Dickinson W. Richards, M.D.—Nominated by Bergen County Medical Society

AMA Clinical Meeting . . . Approved the following report on the 1965 AMA Clinical Meeting, submitted by delegation chairman Joseph P. Donnelly, and commended the delegates for a job well done:

The Medical Society of New Jersey was fully represented at the 19th Clinical Convention of the American Medical Association held in Philadelphia from November 28 through December 1. All seven delegates—Doctors Blaisdell, Donnelly, Greifinger, Hughes, McCall, Mulligan, and Patterson—actively participated in the deliberations of the House and in the discussions of the reference committees. Dr. McCall served as a member of the Reference Committee on Miscellaneous Business and Dr. Blaisdell was an official Teller of the House.

Also present as official representatives were Dr. John J. Bedrick, President; Dr. Joseph R. Jehl, President-Elect; Drs. Jerome G. Kaufman and John F. Kustrup, Alternate-Delegates; and Richard I. Nevin, Executive Director.

Specific reference committee assignments were given to the members of the New Jersey delegation as follows:

Amendments to Constitution and Bylaws—
Dr. Donnelly and Mr. Nevin

Reports of the Board of Trustees—
Drs. Patterson and Blaisdell

Insurance and Medical Service—
Drs. Hughes, Jehl, and Kustrup

Legislation and Public Relations—
Drs. Blaisdell and Kaufman

Medical Education and Hospitals—Dr. Mulligan

Miscellaneous Business—Dr. McCall

Public Health and Occupational Health—
Dr. Greifinger

When the sessions of the committees to which they had been assigned were completed, all delegates freely visited among the other reference committees still in session and participated in their discussions.

At the direction of the Board of Trustees of MSNJ, the New Jersey delegation introduced and supported *Resolution No. 17*, urging the retention of the AMA Council to Improve the Health Care of the Aged.

Resolution No. 17 was sent to the Reference Committee on Reports of the Board of Trustees, where it was considered in conjunction with Supplemental Report E of the Board of Trustees, which dealt with the Joint Council to Improve the Health Care of the Aged. Concerning these two items, the reference committee declared: "Your reference committee heard discussion of this subject by members of the Board of Trustees and other delegates and members. Since the American Hospital Association and the American Dental Association have already withdrawn from the joint council and since existing programs can be assumed by departments within the AMA, your reference committee feels that—while it agrees with the intent of Resolution No. 17—the objectives of that resolution have been accomplished." The reference committee, therefore, recommended that Resolution No. 17 be not adopted, and the House approved the recommendation.

The delegation interested itself particularly in one phase of the Report of the Gundersen Committee to Review the *Organization of the American Medical Association's House of Delegates*, and the related subject matter of Resolutions No. 27 and No. 30.

At issue, it seemed to us, was the oneness and solidarity of the American Medical Association, under a situation which seemed to regard authority and responsibility as divided, rather than shared, between the House of Delegates and the Board of Trustees. In an effort to eliminate this divisive concept, the delegation offered formal remarks which were presented to the Reference Committee on Amendments to Constitution and Bylaws by Dr. Jehl.

The New Jersey delegation also recorded itself—in both the Reference Committee on Reports of the Board of Trustees and in the House—as disapproving any action by the House to indicate support of a *membership dues increase* of $25, to be effective as of January 1, 1967. This would, as of that date, raise the annual AMA dues from $45 to $70 per year.

Actually the House in the 1965 clinical convention had no power to set dues for 1967, since the Bylaws prescribe that dues may be set only for the ensuing calendar year. Yet, under the stimulus of the reference committee, the House—by a split vote—recorded itself as favoring the proposed increase, subject to final action in June 1966 at the annual meeting. The House also approved the reference committee's recommendation that the Council on Constitution and Bylaws study possible changes in the Bylaws which will "allow the finances of the Association to be planned more than one year in advance."

I should like to report to the Board that the members of our delegation all feel that the present schedule followed by the AMA House of Delegates handicaps the members of the House in their attempt to study and arrive at conclusions and positions concerning reports and resolutions submitted to the House. For example, the House met on Monday morning at 9:00 a.m. for the introduction of resolutions and, within 15 minutes of the close of the House, reference committees were being called to order. This means that the delegates were not able unhurriedly to study the resolu-

tions and the reports and in caucus to arrive at their determinations concerning them. There seems to be ample time in terms of days and hours available; but for some reason or other, the time is not efficiently budgeted with reference to the members or the matters being dealt with.

Medicare Law . . . Approved the following report and recommendations of the Council on Medical Services.

The council discussed the provision under Part I-C of the law requiring a "utilization review plan", which is intended to review utilization—on sampling or other basis—and to safeguard against over-utilization. It adds up to self-appraisal by physicians of the adequacy of services being rendered. The primary aim is to keep this appraisal from becoming a function of government, and the council agreed unanimously that it is imperative that each such utilization review committee be headed by a physician. In this regard, the council unanimously *recommended:*

a. That a Subcommittee on Utilization Review Procedures be formed within the council, and its membership consist of: Dr. Eckstein, chairman; Dr. Boylan, Dr. Ruoff, and Dr. Norton.

b. That a Subcommittee on Compensation of Physicians be formed within the council, and its membership consist of: Dr. Benz, chairman; Dr. Gannon, Dr. Brindle, and Dr. Durham.

c. That component societies be immediately alerted to the desirability of appointing utilization review committees to implement Public Law 89-97.

d. That hospital staffs be alerted, through their chiefs of staff, to the desirability of forming utilization review committees in every hospital in New Jersey, and be alerted also to the educational and functional use of these committees as outlined in the Medicare Law.

Disability Determinations . . . Approved the report and recommendation of the Special Committee on Occupational Health, Rehabilitation, and Workmen's Compensation, as follows:

In furtherance of a request from the Department of Labor and Industry for the Society's assistance in an effort to obtain the services of competent unbiased physicians to examine compensation claimants for neurological and neuropsychiatric disabilities, a meeting was called in Newark by the Acting Director of the Division of Workmen's Compensation, which the chairman attended with a member of his committee, Dr. Ruoff, and the Executive Director.

The Council on Medical Services approved the following *recommendation* of the special committee:

That the Society assist the Department of Labor and Industry in obtaining the services of psychiatrists and neurologists, to examine petitioners who claim compensation for neurological and/or neuropsychiatric disabilities.

"Rehabilitating the Disabled Worker" . . . Approved the following report and recommendations of the Special Committee on Occupational Health, Rehabilitation, and Workmen's Compensation, as follows:

The special committee considered the pamphlet and agreed that a need exists for an educational program in the field of rehabilitation. The committee concluded that the most effective means of presenting such information to the members would be through publication of articles in *The Journal* and dissemination of information through secretaries of component societies.

The Council on Medical Services approved the following *recommendations* of the special committee:

1. That the Medical Director of the New Jersey Rehabilitation Commission be requested to abstract pertinent sections of the pamphlet "Rehabilitating the Disabled Worker" for publication in *The Journal.*

2. That the Second Injury Law, with satisfactory detailed explanation, be published in *The Journal* for the education of the membership.

3. That, if (1) and (2) are approved, component societies be informed in advance of the issues of *The Journal* in which such articles are to appear, and urge their members to read them.

4. That component societies be informed that counselors from the Rehabilitation Commission are available, upon invitation, to assist component societies.

Air Pollution Conference . . . Authorized Dr. Roslyn Barbash, Chairman of MSNJ's Committee on Air Pollution, to represent the Society at the AMA Air Pollution Medical Research Conference in Los Angeles on March 2, 3, and 4.

Methadone Is A Narcotic

Mr. George M. Belk, District Supervisor of the Federal Bureau of Narcotics, reminds all doctors that amidone is a narcotic—and not an exempt one. The Bureau considers that this drug has addicting properties and that, under its unofficial name of Methadone, it is subject to full control under the Harrison Act. The classification of amidone (diphenyl demthyl amine heptanone) as a narcotic was through Presidential proclamation 2733, July 31, 1947. The AMA stand on this is detailed in Pamphlet 56 of the Federal Bureau. If you want a copy, write to Bureau of Narcotics, 90 Church Street, New York, New York 10007, and ask for "Pamphlet 56, Maintenance Treatment of Addicts, the AMA position."

BICENTENNALIA

George Franklin Fort: New Jersey's First Physician-Governor

Two physicians have been Governors of New Jersey since elections for that office were first held in the year 1776. George Franklin Fort and William Augustus Newell [who served from 1851-54 and 1857-60 respectively] were eminent figures in the list of 45 heads of the state government over the past 190 years. Dr. Fort, a Democrat, and Dr. Newell, first Republican incumbent in the office, were elected from rural districts — one of the vast changes, political and economic, that have entered into the people's selection of their public officials during the past century.

George F. Fort, New Jersey's 16th Governor, was born at Pemberton on June 30, 1809, in a house that is still standing. A son of Andrew Fort [whose forbear, Roger Fort, had settled in Burlington County around 1700], George was the oldest of ten children.

At age 17 he entered the University of Pennsylvania, receiving a medical degree three years later. His doctoral thesis was entitled, *Hydro-arachnitis Infantum*. Later in the same year (1830) he became a member of The Medical Society of New Jersey.

Dr. Fort set up medical practice at New Egypt, opened a drug store and also became postmaster of the town. He was assemblyman from Monmouth County (New Egypt, now in Ocean County, was then in Monmouth) in 1844 and 1845, and was Monmouth's state senator from 1846 to 1848. While a member of the House and Senate he was a diligent member of the Judiciary Committee.

During his term in the Legislature he helped to prepare and supported the bill, passed in 1845, that provided for the establishment of New Jersey's mental hospital at Trenton, the first state institution of its kind in the United States.

Fort received the nomination for Governor at a Democratic Convention in September 1850. He campaigned on a platform for free schools, tax equalization, and abolition of the requirement that persons must own property to have the right to vote. He had the support of the United Railroad and Canal Company, a dominant political power of the day, and was elected Governor in November 1850.

During his term he worked for improved state banking and for the tax equalization method he had advocated as a candidate. This marked the beginning of the Legislature's assuming responsibility for the taxing systems of municipalities.

In 1863, Governor Joel Parker named him to the Court of Errors and Appeals, where he served until 1871, a year before his death. After his term as Governor he was also a member of a special Prison Reform Commission, which materially improved conditions in the State's penal institutions.

Throughout his political career Governor Fort maintained an interest in medicine, practicing at intervals and accumulating a large medical library. His professional background was a boon in promoting humane care for the mentally ill and for prisoners. A prominent Mason, he wrote a book, "The Early History and Antiquities of Freemasonry," published posthumously in Philadelphia.

Dr. Fort was an uncle of John Franklin Fort (1852-1920), who became New Jersey's 33rd Governor in 1908. Dr. George Franklin Fort died at New Egypt on April 22, 1872. A portrait of New Jersey's first physician-governor, by an unidentified artist, hangs in the State Capitol at Trenton.

Fred B. Rogers, M.D.

Gloucester County Medical Society*

In 1818 the Gloucester County Medical Society was organized. Gloucester County then included what is now Camden County. The boundaries of Gloucester reached from the Delaware to the sea.

Before 1818, since there was no law regulating the practice of medicine in New Jersey, the medical code of the Duke of York was more or less followed. It was said "Quacks abounded like the locusts of Egypt." And that "medicine was administered by women except in extraordinary cases." "Brimstone and Vinegar" was one remedy to be taken every night on going to bed and in the morning before getting up and three or four times between "drinking some warm liquid to wash it down." One settlement on the Delaware was completely broken up because of smallpox, venereal disease, and the typhoid.

During an epidemic of yellow fever in 1798 (said to have originated on the shores of the Delaware), a Doctor Lummis of Woodbury wrote to a Philadelphia doctor blaming the air of the meadows for the outbreak. Apprenticeship, living a year or so as a physician's assistant, was all the medical education doctors commonly had.

Dr. Thomas Hendry — born in Burlington, later settling in Woodbury — was in active general practice, Superintendent of Hospitals of Gloucester County, and a surgeon. He was also chief clerk of Gloucester County. His son, Bowman Hendry, practiced in Haddonfield; and grandson, Bowman Hendry, in Camden.

On November 10, 1818, "Gloucester County District Society" was organized with the following members: Doctors Thomas Hendry, Dayton Lummis, James Fithian, Lorenzo Fisler, Isaac Davis, Benjamin Erwin, Francis Hoover, William Hunt, Samuel Harris, Bowman Hendry, J. J. Foster, Ezra Baker, and John Wainer. This group held meetings for three years and was discontinued to reorganize in 1835 with six members. Failing to submit for inspection their Constitution and By-laws, it was not recognized by the State Society. Not until 1846 was approval obtained. Dr. Joseph Fithian was President of the State Society in 1849 and Dr. Sickler in 1859. It was said of Dr. Bowman Hendry that he was distinguished for his courtesy and kindness, punctuality, industry and zeal; that "he elevated medical standards and rescued obstetrics from the hands of midwives." He rode in the saddle for fifteen years and was said to have exhausted two hundred horses in his service.

Minutes now preserved were not kept regularly until April 25, 1883. Meetings continued three to four a year. Dr. Henry Diverty became a member in 1887. Dr. George Reading was elected secretary and kept that office for thirty-five years — until he died in 1924.

It was in 1894 that delegates were appointed to the AMA convention and state and county meetings. On September 15, 1898, the Society celebrated its 80th anniversary at Wenonah Inn. A special coach for free use of invited guests left Philadelphia at 1:30 p.m. and returned from Wenonah at 10:14 p.m.

The debut of the annual Social Session was September 14, 1899. In 1918 elaborate preparations were made for celebrations of the Society's centennial anniversary with a banquet at the Wenonah Military Academy.

In 1922, Dr. James Hunter was President of The Medical Society of New Jersey. Membership increased from 29 in 1924 to 70 in 1960.

After a peaceful interim of 19 years (from 1898 to 1917), World War I and an epidemic of influenza broke the even tenor of our way of life. Dr. Underwood related his experiences, climaxed by a day of 63 calls, 7 deliveries and going to sleep at the wheel of his car which traveled uncontrolled into a ditch.

Dr. Wendell J. Burkett was the one member in military service in 1918. Dr. Ralph K. Hol-

* Prepared by Dorothy M. Rogers, M.D., of Gloucester County.

linshed was 151st State President in 1943. A second peaceful interim was broken by World War II. Then we had 41 members in the various branches of military service. In addition, dozens of our younger members have served in post-war (cold war) efforts in many ways and places.

Regular meetings have continued without omission until the present time. The present membership is 77 Active, 7 Courtesy, 1 Emeritus, and 2 Exempt while on Military Service.

OBITUARIES

Dr. Arthur M. McCarthy

On January 4, 1966, Dr. Arthur M. McCarthy, one of Camden County's senior and most beloved general practitioners, died suddenly. Dr. McCarthy was 72 years old at the time of his death. He received his M.D. degree at the Medical School of the University of Pennsylvania in 1919. He was active on the staff of the Cooper Hospital and in various Camden civic and country club affairs.

Dr. John J. Reason

As the old year faded, New Jersey medicine lost one of its senior members with the death on December 22, 1965 of Dr. John J. Reason. Born in 1876, he received a Ph.G. degree at Columbia University at the age of 20. He immediately entered the medical school of the University of Maryland, obtaining his M.D. degree four years later. He then moved to Carteret and began a 60-year period of service to the people of Middlesex County. He interrupted this in 1917 to serve in the medical corps of the United States Army. He was one of the organizers of Post 263 of the American Legion and was active in Middlesex County medical, civic, and veterans affairs for many decades. In 1957 he was one of the laureates of our Medical Society's Golden Merit Award.

Dr. William H. Varney

Dr. Varney died on January 10, 1966, as he would have wished: while making rounds at the Warren Hospital. Born in 1905, he was a 1928 graduate of the medical school of the University of Maryland. He became a general surgeon and was a member of the International College of Surgeons. Dr. Varney was on the staff of the Warren Hospital in Phillipsburg. He served the Warren County Medical Society in all its offices, including a successful term as president of that component. He was director of the County Tuberculosis Association and of the county division of the American Cancer Society. He was active in civic affairs and had been president of the Kiwanis of Washington, New Jersey. Dr. Varney was a member of the Warren County Health Board. He was 60 years old at the time of his death.

Dr. John F. Weber

At the age of 76, Dr. John Francis Weber, a prominent Middlesex County practitioner, died on January 6, 1966. Dr. Weber earned his M.D. degree at the University of Pennsylvania in 1913. Three years ago he was a golden medal laureate of The Medical Society of New Jersey. For many years, he was chief of staff at the South Amboy Memorial Hospital, and he also served both the Roosevelt and the Perth Amboy General Hospitals. He saw active military duty in our Army in 1917 and 1918.

ANNOUNCEMENTS

Course for Industrial Physicians

Columbia University announces an intensive one-week course for physicians in industry, starting March 7. For details, write to Columbia University School of Public Health at 21 Audubon Avenue, New York, New York 10032.

Learning Disabilities

A special symposium on learning disabilities is scheduled for the afternoon of April 29 at Records Hall, Rutgers Hall. Advance registration is required. For further details, write to Symposium, P. O. Box 126, North Branch, New Jersey 08855.

Hypnosis Course in Montclair

Starting on March 2, 1966 — and every Wednesday thereafter — a course in clinical hypnosis will be held evenings from 7:30 to 10 p.m. at Mountainside Hospital in Montclair. Limited to 20 selected students, the program will include lectures and supervised practice. The sponsoring agency is the New Jersey Society for Clinical Hypnosis — which, incidentally, can furnish you with a speaker to discuss hypnosis in medical and dental practice. For more details on either the course or the speakers' panel, write to Dr. K. A. Bartlett at 460 Bloomfield Avenue, Montclair.

Chemotherapy of Solid Tumors

At noon on Wednesday, February 23, a unique symposium will be held at the St. Elizabeth Hospital, 225 Williamson Street, in Elizabeth. This meeting is under the joint sponsorship of the Academy of Medicine of New Jersey and our State Health Department. Professor B. J. Koven will discuss the treatment of lymphomata, while Doctors Burton Lee and Robert Golbey (both from Sloan-Kettering) will review chemotherapy of solid tumors.

Sex in Medical Practice

On Thursday evening, February 24, Dr. Jules Masserman of Northwestern University will talk about sex in medical practice at a meeting of the Psychiatry Section of the New Jersey Academy of Medicine. The session will start at 8 p.m. and be held at the State Hospital, Marlboro, New Jersey. The hospital is reached via exit 109 of the Garden State Parkway. Aided by a grant from Wallace Laboratories, a collation will be served after the meeting. The New Jersey Neuropsychiatric Association and the county medical societies of Middlesex, Monmouth, Ocean, and Union are co-sponsors.

Symposium on Strokes

Friday, February 25, at 11 a.m. is the time and the Warren Hospital in Phillipsburg is the place for a symposium on strokes sponsored jointly by the State Health Department and the New Jersey Academy of Medicine. Speakers will be Arthur Winter, M.D., Bernard S. Epstein, M.D. and Henry Shenkin, M.D.

VA Chief of Staff

Announcement has been made by the Veterans Administration of the appointment of Winston C. Hainsworth as chief of staff of the Veterans Administration Hospital in East Orange. This title corresponds to what was previously called clinical director.

Dr. Hainsworth holds his M.D. from the University of Virginia and his professional background has been in the field of pediatrics, in which specialty he is a board diplomate.

REVIEWS BOOK

Current Concepts in Medical Practice. Edited by John E. Mullins, M.D. St. Louis, 1965, Mosby. Pp. 436, illustrated. ($10.75)

A number of everyday medical problems are neatly compressed into this fabrikoid-bound single volume. The list includes the commoner disorders in ophthalmology, neurology, arthritis, cardiovascular disease, hematology, nephritis, endocrine disorders, and pulmonary, liver, and gastro-intestinal diseases. Most of the articles are written with clarity and conciseness; some of them with wit; and all of them with wisdom. Exceptionally rich bibliographies at the end of each chapter add to the book's usefulness.

VICTOR HUBERMAN, M.D.

Functions of the Corpus Callosum. Edited by E. G. Ettlinger, Ph.D. Boston, 1965, Little, Brown and Company. Pp. 156, with 28 illustrations. ($3.75)

In the fall of 1964, the Ciba Foundation brought together a galaxy of neurologists, physiologists, anatomists, psychologists, and clinicians. With the permission of Lord Adrian, they dedicated this colloquium to him. They talked about the brain's large commissure: the corpus callosum. They reviewed its anatomy, its physiology, and the clinical manifestations of callosal disorders. This is a book for specialists or for those who can go, in depth, into a study of this intriguing but little understood part of the brain.

HERBERT BOEHM, M.D.

Complex World of Modern Public Health. By Luther L. Terry, M.D., Surgeon General, U. S. Public Health Service. Washington, D.C., 1964, American Public Health Association. Pp. 36.

Among physicians in the U.S. today, the most popular conversation piece is the changing relationship of medicine to Government. No physician can ignore such statements as this by Dr. Terry because of the insights it gives us into the needs and the planning for the development of public health in this country. Dr. Terry suggests that the primary concern of both the private and public sectors of medicine should no longer he a dialogue over where the borders should be drawn between them, but rather a common declaration of interdependence. Acknowledgement of this interdependence follows upon recognition of the emergence of ecologic changes initiated by man's own scientific advances. Even prior to the widely heralded *Silent Spring* by the late Rachel Carson, Dr. Terry points out that Public Health Service research was being directed toward the problem of the appearance of DDT in marine life as far distant as the Arctic Circle.

The citations of the three men winning the awards are indicative of the type of work necessary for the implementation of public health programs. Dr. Terry sees these three men—Dr. Harold D. Chope of San Mateo County Health Department; Dr. Herman Hilleboe, former Commissioner of Health of New York State; and Mr. Marion Folsom, then Secretary of Health, Education and Welfare—as representative of the participation essential to health planning at local, state and national levels.

SHIRLEY A. MAYER, M.D., M.P.H.

Complement. Edited by G. E. W. Wolstenholme, O.B.E. and Julie Knight, B.A. Boston, 1965, Little, Brown and Company, Pp. 338, illustrated. ($12.50)

This symposium of the Ciba Foundation is a compilation of talks by world authorities concerning the identity of complement, its role in hemolysis, its effects on nucleated cells, immune reactions, phagocytes, conglutinin, hemolytic processes, disease processes, delayed hypersensitivity reactions, and complement deficiency.

H. J. Miller-Eberhard and A. P. Dalmasso of the Scripps Clinic and Research Foundation give a concise presentation of the book's objectives: "The past few years have seen encouraging developments in the biochemical elucidation of the complement system. At least ten distinct factors are presently recognized as essential parts of the system; some of these have been isolated and characterized and one could safely be identified as enzymes. There is much hope, therefore, that the puzzle of the complement reaction and the effect of complement on cell membranes will he solved in the foreseeable future and will then be describable in simple biochemical terms."

The reviewer feels that the earlier a uniform terminology is applied to the various elements in the complement system, the sooner will additional discoveries and comprehension of its role in biologic reactions be achieved.

T. K. RATHMELL, M.D.

How to Live with Diabetes. Henry Dolger, M.D. and Bernard Seeman. Revised Edition. New York, 1965, W. W. Norton & Company, Inc. Pp. 201. ($4.50)

In this revised edition of a book, deservedly popular with physicians and laymen, the authors bring the newer concepts of diabetes into focus with easily intelligible language.

As stated in the new foreword: "The newer oral drugs are discussed in detail; their characteristics, the areas in which they are useful, their modes of action insofar as they are known, and the dosage forms now available." The concept of the "prediabetic stage," which has been crystallizing in the thought of diabetic specialists, is discussed in the light of current research and the developing possihilities of diabetes prevention.

A few new paragraphs explain the origin and action of glucagon, now used to treat insulin reactions. The paragraph on the similar use of epinephrin is omitted. There are extensive revised figures for the number of diahetics in Great Britain and the United States, as well as interesting data from Natal, South Africa, and Israel. In the section on diet, the foods sweetened with sugar substitutes are mentioned and the general principles of dietary treatment are repeated. The new disposable plastic syringes for insulin injections are noted.

The original edition of this work was a fascinating, informative, readable book containing the history of the disease, extensive descriptions of the various types of insulin, the complications of diabetes, and a sympathetic discussion of the problems presenting during childhood, adolescent, and adult diabetic lives with a special chapter on the problems of women diabetics. The new edition is equally recommended as an up-to-

date revision for physicians reading and patient instruction on general principles for the care of the diabetic. EVERETT O. BAUMAN, M.D.

From Auscultation to Phonocardiography. Aldo Luisada, M.D. St. Louis, 1965, Mosby. Pp. 351. With 196 illustrations. ($17.75)

I asked several competent clinical cardiologists what they were able to gain from the use of phonocardiography. Most of them did not use it at all. The others felt that little was added to clinical auscultation. I wondered whether the method or the training of the men was at fault. After reading the book, it seems clear that it is something of both. This discipline is intrinsically difficult. The apparatus which includes microphones, amplifiers, equalizers, filters, and recording systems is not completely standardized. Even the application of the microphones to the chest wall is by no means agreed upon.

Luisada feels that a technician requires a year of training; a resident physician, six months; and a cardiology oriented internist, one month. When to this must be added differences of opinion on interpretation as well as some question as to the mechanism of normal and abnormal heart sounds, we are left with a bit of a problem.

Luisada, in a scholarly and objective manner, attempts to bring order to this highly interesting and valuable method. The book is an admirable compilation of current knowledge of transmission of cardiac sounds.

If the book lacks somewhat in readability, we may ascribe it to the difficulty of the subject and perhaps to the lamentable fact that scientists are usually not literary giants. M. E. LANDSMAN, M.D.

Physical Examination Of the Joints. William P. Beetham, Jr., M.D., Howard F. Polley, M.D., Charles H. Slocumb, M.D. and Walt F. Weaver, M.D. Philadelphia, 1965, Saunders. Pp. 198, illustrated. ($7.50)

The authors start out on a worthwhile mission. Many will read this book and feel edified rather than fulfilled.

Unfortunately, not from the fault of the book but rather of the subject matter, I found certain sections were full of academicisms. These portions read like a series of reflections seen in two mirrors: the reflection of a previous textbook from which the material came could be sensed and behind that the book previous to it, and behind the previous one, the one previous to that. These images carried into the present some ideas which are maintained by tradition but which have lost their significance to clinical medicine. These weak areas basically are examples of the difference between what the "gown" thinks in contrast to what is thought "in town."

For example, a student reading the section on the examination of the back does not get a clear picture of what is really important to look for in a physical examination. This lack reflects the present state of ignorance concerning this phase of medicine today. There is disagreement on the pathologic changes that actually occur in this area, and there is also some disagreement and confusion regarding the interpretation of some of the physical findings. The authors are not much help in leading a reader who has little previous experience with this problem to formulate a routine of physical examination which might point to a diagnostic conclusion, nor to know what is important and what is unimportant.

The section on examination of the hands is well illustrated, but is not as comprehensive or as well organized as the standard textbooks on hand surgery. The section on the knee would perhaps gratify a rheumatologist (pages are spent in describing effusion). It doesn't describe well the procedures ordinarily used in obtaining objective evidence of mechanical knee derangements.

This book would have been of greater value if it emphasized points needed by treating practitioners to arrive at a diagnosis or to pick up physical signs necessary for the understanding of underlying pathologic or physiologic principles. This would help us treat patients rather than emphasizing the finer descriptive points that may not be as important particularly for the ultimate goal: therapy.

These faults are shared by many books written by rheumatologists. They are writing about an as yet unsolved problem for which therapy really isn't satisfactory and even the etiology (and therefore a teleologic description of the pathology) is lacking. Even a book concerning the physical diagnosis of the areas involved cannot be entirely satisfactory under these circumstances. HARRY MERLISS, M.D.

Current Concepts of Thyroid Disease. A programmed self-instructional review for physicians. Developed by Pfizer Laboratories, Inc., SPECTRUM and Basic Systems, Inc. New York, 1965, Chas. Pfizer & Co., Inc. Pp. 93 (Distributed as an educational service)

Current concepts of Thyroid Disease is the second in a series of self instructional programmed reviews for the general physician. This approach to learning is based on unproved theories concerning the reinforcement phenomenon. The critical question is whether the text succeeds in its goal—to "review the fundamental considerations in the diagnosis and treatment of thyroid disease, and to bring you up to date on some of the more recent developments in this field." I believe that the guide *does* succeed in accomplishing its mission as a basic primer on thyroid disease. However, there is one weakness in this type of learning procedure: it remains superficial. As is true of any short answer or multiple choice system, there is no way to indicate differences of opinion, to clarify or discuss nuances in theory or management. This ingenious and successful *basic* primer on thyroid disease cannot substitute for a well written, up-to-date text on the subject. With these points made, this guide can be recommended for those interested in a concise review of the diagnosis and treatment of thyroid disease.
RICHARD L. FOGEL, M.D.

Cardiomyopathies. Edited by G. E. W. Wolstenholme, M.A. and Meave O'Connor, B.A. Boston, 1965, Little, Brown and Company. Pp. 428, illustrated. ($12.50)

This book is based on a 1964 symposium sponsored by the Ciba Foundation. It includes not only the papers presented by an outstanding group of speakers but also the discussions which followed each presentation. The initial chapter is by J. McMichael, who opened the symposium by quoting William Boyd—"of all the ailments which may blow out life's little candle, heart disease is the chief." The term "cardiomyopathy" was introduced by W. Brigden to cover subacute and chronic disorders of heart muscle of obscure etiology. It includes both the hypertrophic-obstructive type and the conventional congestive failure in a large flabby heart and low cardiac output which may be due to

infection or some sort of poisoning. It is the former which was discussed and stressed at the symposium. There were papers dealing with the clinical recognition, physiology of cardiac contraction, histochemistry, electron microscopy, and the hemodynamic effects of circulatory drugs. Drug induced myopathies from such drugs as reserpine and guanethidine were reviewed.

Results of operative treatment in idiopathic hypertrophic subaortic stenosis were thoroughly discussed. Also included were brief chapters on other forms of cardiomyopathy, myocardial fibrosis, Friedrich's disease, and viral myocarditis.

This book is highly recommended to cardiologists, particularly for a review of this important subject, about which there is an awareness, but little understanding. There is a wealth of material within this volume not easily accessible to the average reading physician.

JEROME G. KAUFMAN, M.D.

Introduction to Developmental Psychiatry. B. C. Bosselman, M.D.; I. M. Rosenthal, M.D.; and Marvin Schwarz, M.D. Springfield, Illinois, 1965, C. C. Thomas. Pp. 139. ($6.50)

Rigidly adhering to the conventional psycho-analytic formulation, the authors reconstruct personality development from birth to adolescence. They review disorders of sleep, eating, social behavior, and elimination, interpreting these in standard analytic terms. There are chapters on adaptation to maturity, the crises of adolescence, the hospitalization of children, sexual identification, learning, neurotic anxiety, and character disorders. The book seems to be beamed at the medical student or possibly at students of social work, nursing, and psychology. The authors have achieved the none too easy task of presenting material in correct terms, without talking down to the reader and without overwhelming him with jargon.

ABRAHAM LEFF, M.D.

Give and Take. Francis D. Moore, M.D. Garden City, N.Y., 1965, Doubleday (Anchor Books). Pp. 216, Softback ($1.25)

Surgeon-in-Chief at Peter Bent Brigham, Dr. Moore beams this book at the sophisticated layman. It is an interesting account of skin grafts, organ transplants, and tissue transplantation generally. It is told lucidly, and is salted by the distinguished author's philosophical and ethical musings on the subject.

ULYSSES S. FRANK, M.D.

Brain-Thyroid Relationships. Edited by Margaret P. Cameron, M.A. and Maeve O'Connor, B.A. Boston, 1964, Little, Brown and Company. Pp. 117, with 28 illustrations. ($1.95)

"Brain-Thyroid Relationships" is another in a series designed to permit recent experimental work of clinical significance, to be published in rapid fashion. Here are six articles covering topics such as: the effect of hypothalamic function on the thyroid gland, the effect of thyroid gland function on the hypothalamus, and psychologic studies relating to thyroid dysfunction. Discussions follow the major papers. Each essay was interesting and provocative. Much of the data has not yet been published in the clinical literature. Since the material is presented in experimental format, the book is not likely to find its way onto the clinician's shelf. However, this volume is certainly suitable for the medical library. It will be enjoyed by those interested in the field of thyroid physiology.

RICHARD L. FOGEL, M.D.

Management of the Patient with Subnormal Vision. Gerald Fonda, M.D. St. Louis, 1965, C. V. Mosby. Pp. 161 with 88 Figures. ($11.00)

This eminently practical and useful book accomplishes precisely what the author says his purpose is: "The correction of subnormal vision is only an extension of the routine eye examination. It has been made complicated and elaborate by lack of knowledge and by the influence of strong merchandising tactics."

The presentation is based on Dr. Fonda's extensive personal experience and is replete with sensible suggestions for the handling of this type of patient. One such simple device is what is referred to as "non-optical magnification" obtained at no cost, great efficiency, and without reduction of visual field—merely by reducing the distance between the observer and the object of regard.

The discussion of the various types of visual aids is accompanied by examples, illustrations, and explanations of the optics involved. The indications and limitations of each type are carefully presented. Dr. Fonda figuratively takes his reader by the hand and leads him through the testing procedure, the decision as to the type of aid to be prescribed, the final prescription, and how it is reached and the instructions to the patient.

This book requires and repays careful study. The knowledge found between these covers is a necessity for the ophthalmologist who would conscientiously serve his patients.

S. JEROME GREENFIELD, M.D.

Ophthalmology: Principles and Concepts. Frank Newell, M.D. St. Louis, 1965, Mosby. Pp. 491 with 172 illustrations. ($12.25)

Intended as an introduction to basic ophthalmology for under-graduate and graduate students, this text emerges into a well populated world of textbooks written for this level. It devotes almost a quarter of the text to a readable discussion of the basic sciences. This is of utmost importance in understanding the clinical section. The latter lays stress on the important diseases, and ocular signs of systemic disorders. Omitted are areas in which the nonspecialist rarely becomes involved such as refraction, optics and biomicroscopy. The illustrations are good, and many are original and well thought-out.

I recommend this book to all students, and especially as a first introduction to a physician desiring to specialize in ophthalmology. As a general reference for the practitioner of internal medicine, this text will certainly be appreciated.

HOWARD M. EISENSTODT, M.D.

A Synopsis of Contemporary Psychiatry. G. A. Ulett, M.D. and D. W. Goodrich, M.D. Ed. 3. St. Louis, 1965, Mosby. Pp. 299. ($6.75)

For more than a decade, the compact little Ulett-Goodrich text has been a useful *vade mecum* for North American doctors. This third edition thoroughly updates the volume. As with all "synopses," there is the complaint of superficiality. The whole field of psychotherapy, for example, is covered in eleven pages; the growing problem of barbiturate addiction gets a once-over lightly treatment in only seven lines. But you can't have everything—and the medical student, house officer, or neophyte psychiatrist will find this a handy ready-reference work. An exceptionally rich roster of "suggested readings" makes this a most useful primer. The wonder is how the authors managed to pack so much meat into so small a body.

FELIX A. UCKO, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

FEBRUARY, 1966 • VOL. XXXIX, NO. 2

ETIOLOGY OF ACUTE RESPIRATORY INFECTIONS

In a study organized by the Working Party on Acute Respiratory Virus Diseases of the Medical Research Council of Great Britain, 575 positive cultures were obtained from 1,888 children and adults living at home. Illnesses covered the range of prevalent mild disease.

In recent years many previously unknown viruses have been isolated from the respiratory tract of patients suffering from respiratory diseases of various sorts. Some of these viruses cause respiratory disease in such groups as children admitted to hospitals, military recruits, and medical students. However, most acute respiratory diseases occur in persons living at home. Little has been known of the causes of such diseases.

In June, 1961, a collaborative study was inaugurated to investigate a large number of acute respiratory infections in a cross-section of the population. The study continued to June, 1964, with work carried out in 24 centers in Britain. Standard laboratory methods were used for virus isolation.

Children up to 16 years of age who were living at home were first studied. Later, the scope of the investigation was widened to include adults at home or at work. Children in hospitals were also studied to determine whether viruses recovered from small children with severe respiratory disease were the same as those found in milder cases in general practice.

Specimens — usually a throat swab and a nasal swab — were collected from 1,888 patients with acute respiratory infections. On culture, 575 were positive. Patients were examined clinically and the history and diagnosis were recorded on a standard form.

Agents Isolated

A virus or hemolytic stretptococcus was isolated from one patient in three below the age of 17 and from one in four aged 17 or over. Viruses were relatively more common in patients below the age of 6.

Influenza viruses were isolated in the first three months of each year in a pattern which reflected the national prevalence of infection. Para-influenza viruses of all three types appeared each winter in scattered areas and the returns suggested that some areas had sharp outbreaks lasting a few weeks.

Respiratory syncytial (R.S.) virus was isolated by most laboratories. Enteroviruses were isolated mainly from children under 6, but also from those up to 10, and adenoviruses and enteroviruses were found roughly equally in all age groups up to 10. Herpes simplex and rhino-viruses were isolated with almost equal frequency from all age groups, and the pattern with influenza was the same, except that this virus group seemed to pass by infants less than a year old.

Two or three pathogens were obtained simultaneously from 25 patients. In 18 instances one organism was the streptococcus, but each case was classified as infected by the virus isolated.

Serological typing of the viruses showed that

Report prepared by Dr. D. A. J. Tyrrell; *British Medical Journal*, August 7, 1965.

para-influenza viruses 1 and 3 were each about twice as common as type 2. Adenoviruses types 1, 2, and 5, the "endemic" types, were found about as often as the "epidemic" types, mainly represented by type 3. Polioviruses were uncommon. The coxsakieviruses of group A most commonly found, types 2, 4, 5, 6, and 10, are those associated with disease such as herpangina. All serotypes of coxsackieviruses of group B except type 6 were found. Only echovirus type 6 was found in appreciable numbers.

Colds Most Common

Most of the patients were suffering from mild infections of the upper respiratory tract. The largest number of cases — 437 — was diagnosed as the common cold. Sore throat accounted for 376 diagnoses; feverish cold, 341. Next came bronchitis, 179; influenza, 144; "croup," 127; pneumonia, 103; bronchiolitis, 46; otitis media, 42; and miscellaneous conditions, 93.

Pathogens were recovered most frequently from cases of sore throat; half of these were streptococci. Isolations from patients with colds (94 of 437, or 21 per cent) may have been unsuccessful because so little virus was shed or because the tests used would not detect the viruses causing the disease; the latter suggestion is supported by evidence that some of the viruses which are presumed to cause colds cannot be isolated in any known culture system.

An analysis of the medical histories of the patients showed that blockage and running of the nose were each recorded in about half the virus infections, but the nose was relatively drier in adenovirus infections and wetter in enterovirus and rhinovirus infections. Nasal symptoms were less common in streptococcal illnesses. Sore throat was uncommon in parainfluenzal infections and common in adenovirus, enterovirus, and streptococcal infections. Cough was common in infections with the myxoviruses but also occurred in infections with enteroviruses and streptococci and in over half the rhinovirus infections. Hoarseness was noted in infections by all virus groups, but was found most often in influenza and parainfluenza virus infections. Chest pain in enterovirus infections may have been due to myalgia, but was generally uncommon. Wheezing was slightly more common, being part of the clinical picture of bronchiolitis caused by R. S. virus, but was also found in about one in 10 patients infected with other viruses except influenza. Febrile symptoms were common in influenza, adenovirus, and enterovirus infections, and also in those due to streptococci. Their apparent absence in R.S. infections may have been due chiefly to the youth of the patients; in rhinovirus infections it showed that many illnesses were very mild.

Such physical signs as obstruction of the nose and nasal discharge were present in more than half the infections except those due to enteroviruses or streptococci. Chest signs (rales and rhonchi) were most common in infections due to the R.S. virus.

Family Data

When records for the entire family were analyzed, it was apparent that the preponderance of infections of small children was with parainfluenza viruses, R.S. virus, and adenovirus types 1, 2, and 5, suggesting that these are among the first viruses to invade the family.

Respiratory diseases are difficult to describe exactly. The information reported on clinical syndromes and signs and symptoms may be criticized because of the combined effect of observer error and differences in diagnostic labelling among clinicians. In support of their validity is the fact that the association between certain symptom complexes and certain virus infections was evident in the figures from individual centres analyzed separately.

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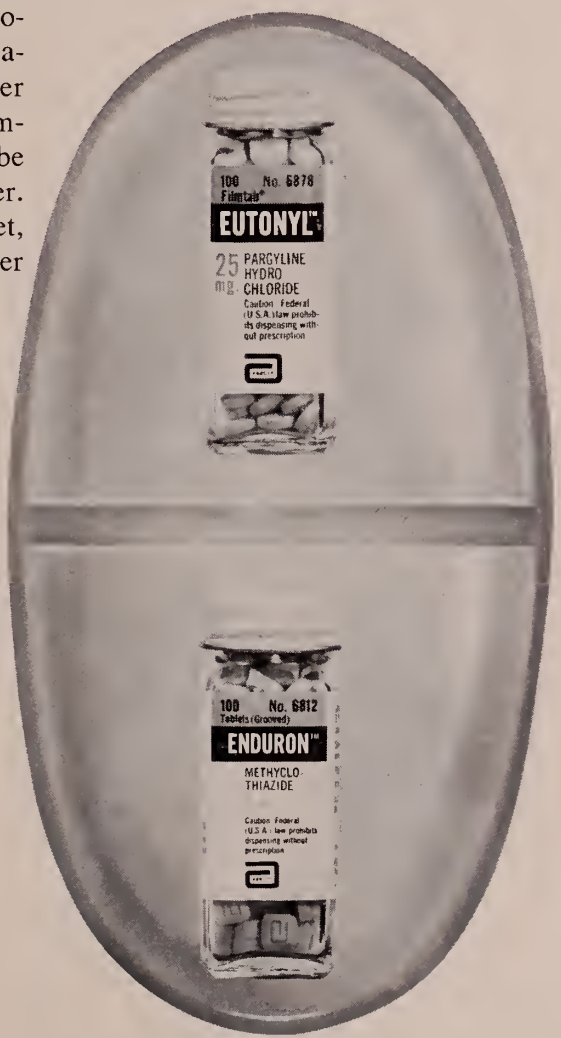
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1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.



BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



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CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

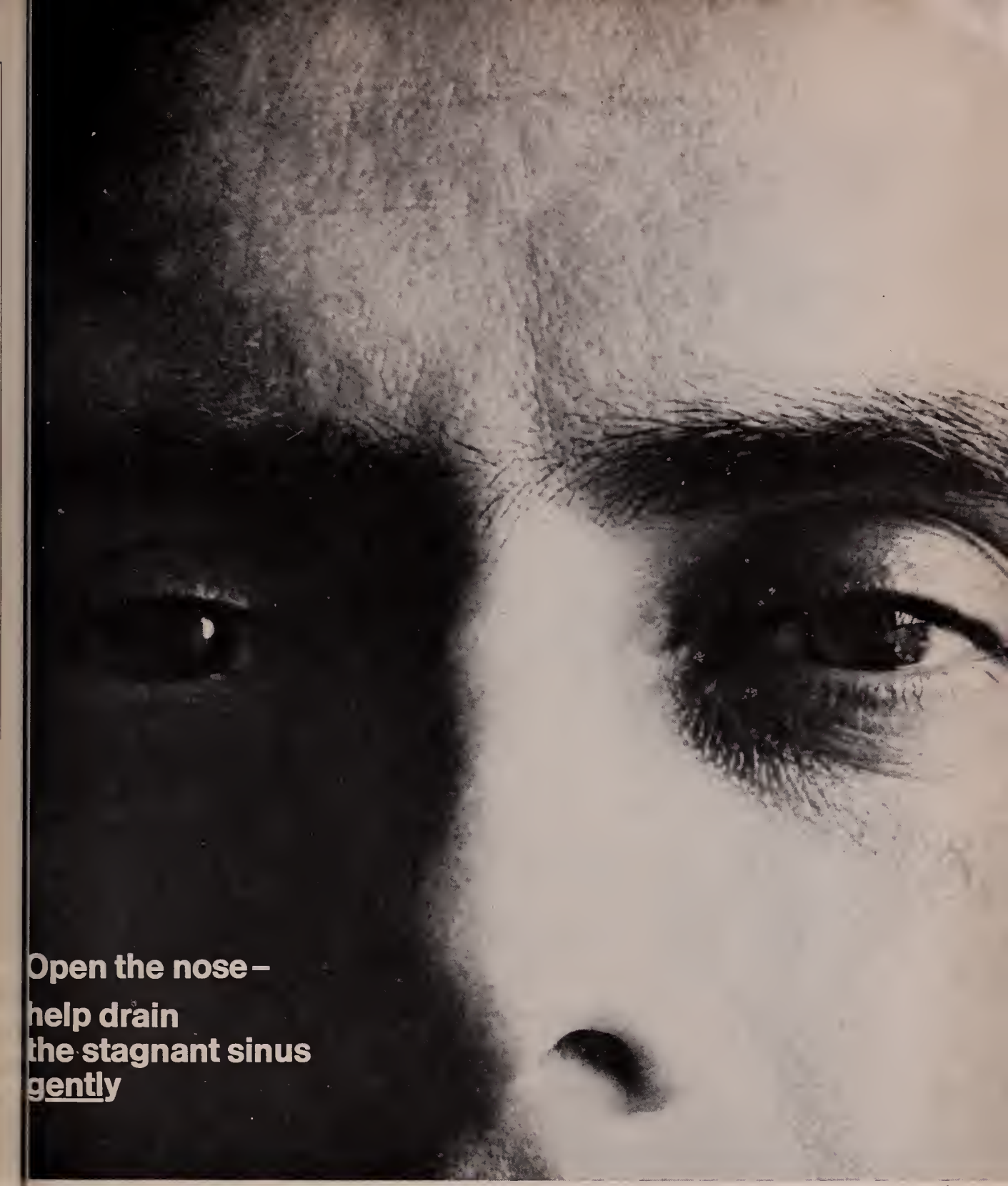
PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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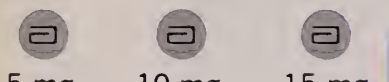
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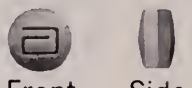
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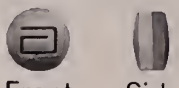
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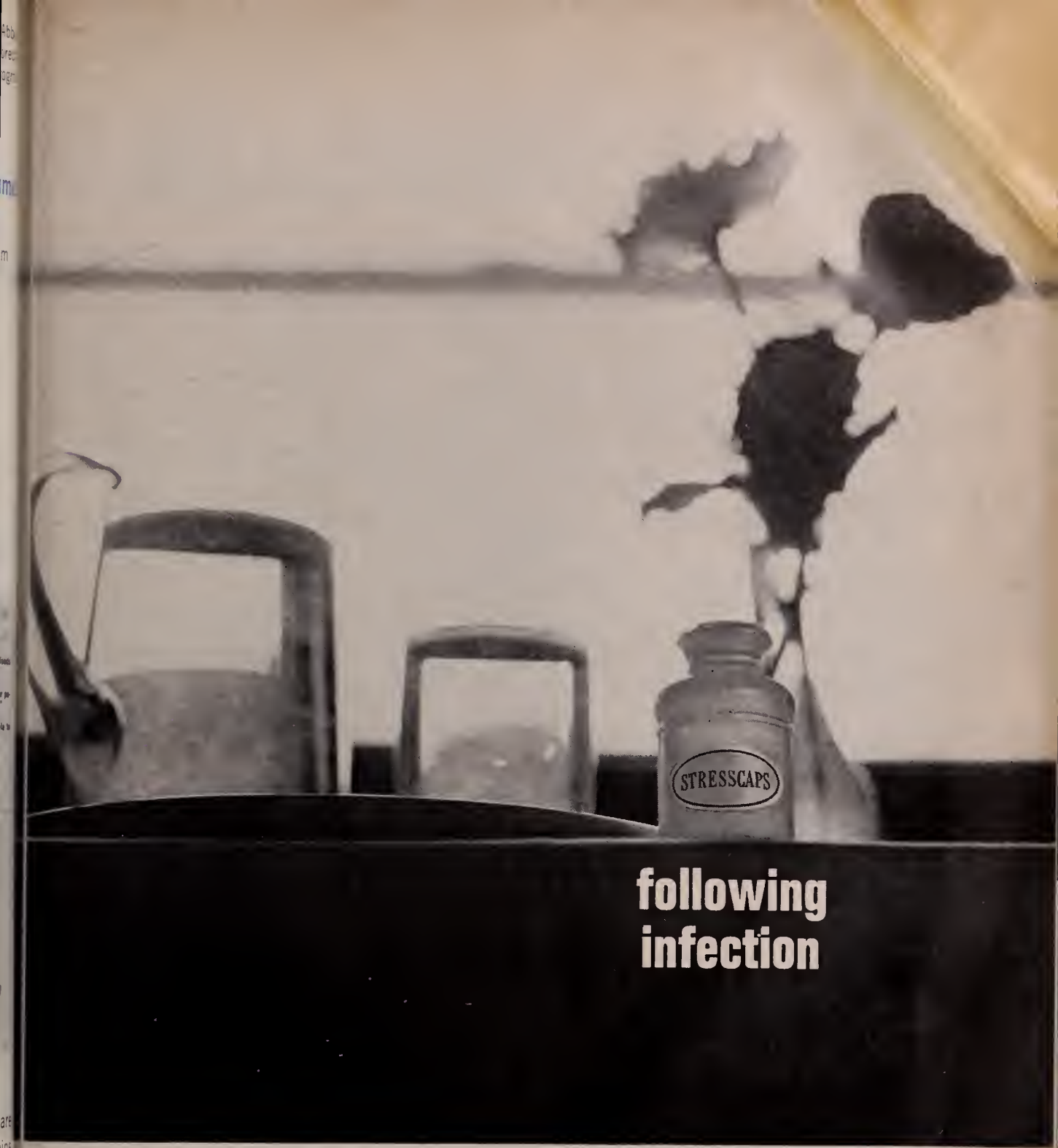
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THE MEDICAL SOCIETY OF NEW JERSEY
BICENTENNIAL ANNIVERSARY MEETING

Saturday-Wednesday, May 14-18, 1966
Haddon Hall, Atlantic City

DAILY SCHEDULE

Friday, May 13, 1966
5:00 p.m.—Board of Trustees

Saturday, May 14, 1966
10:00 a.m.—Registration Opens
2:00 p.m.—Golden Merit Award Ceremony
followed by
Reception for Award Recipients and Their Families
4:00 p.m.—House of Delegates
followed by
Open Discussion on Medical-Surgical Plan
5:30 p.m.—Hudson County Reception for President Bedrick (by invitation only)
8:00 p.m.—Nominating Committee

Sunday, May 15, 1966
10:45 a.m.—Reference Committees
12:00 noon—Exhibits Open
2:00 p.m.—House of Delegates (election)
3:00 p.m.—General Session on Medicare
6:00 p.m.—Reception for President-Elect Jehl

Monday, May 16, 1966
9:30 a.m.—Scientific Sessions:
Clinical Pathology, Medicine, Rheumatism
Gastroenterology and Proctology, Metabolism, Surgery
Allergy, Dermatology, Pediatrics
Ophthalmology, Otolaryngology
12:30 p.m.—Special Luncheons
2:00 p.m.—Scientific Sessions:
Anesthesiology, Obstetrics and Gynecology
Cardiovascular Diseases, Chest Diseases, General Practice
Radiology, Urology
Psychiatry and Neurology
6:00 p.m.—Reception and Dinner for Technical Exhibitors ($5.00 per person)

Bicentennial Day—Tuesday, May 17, 1966
9:30 a.m.—Scientific Program
12:30 p.m.—Luncheon
2:30 p.m.—General Assembly on History and Medicine
5:00 p.m.—Exhibits Close
5:30 p.m.—Reception by Atlantic City Convention Bureau
7:00 p.m.—Dinner-Dance ($10.00 per person)

Wednesday, May 18, 1966
10:00 a.m.—House of Delegates
1:00 p.m.—Delegates' Luncheon
2:00 p.m.—House of Delegates—continued
2:30 p.m.—Registration Closes
3:00 p.m.—Board of Trustees

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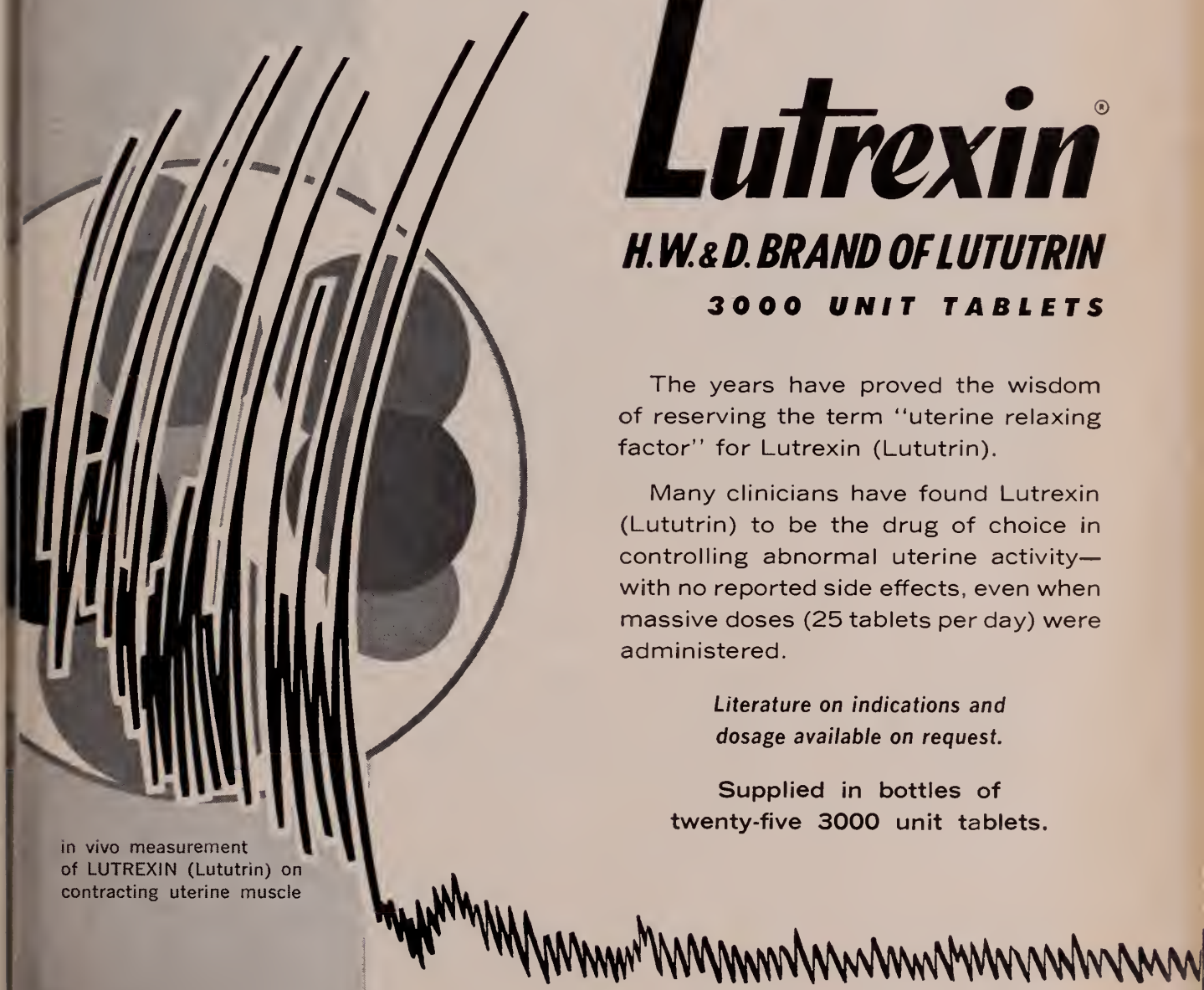
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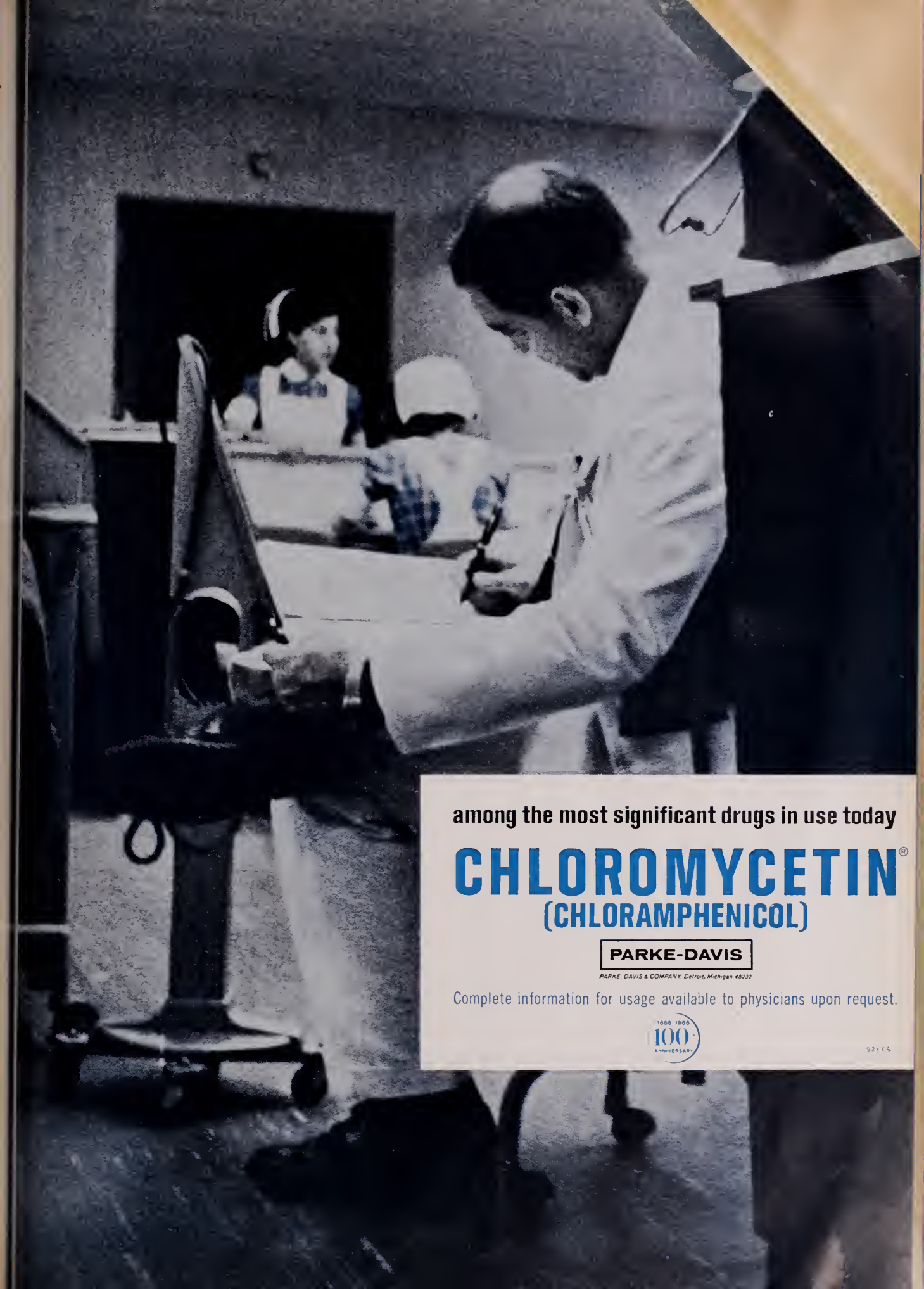
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CONTENTS • Pages 77 to 114

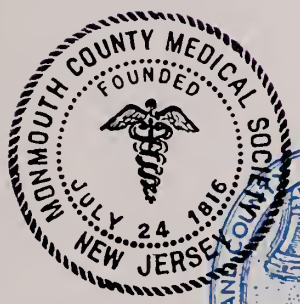
EDITORIALS
In Our Journal Fifty Years Ago . . 77
Pathfinder Through the Drug Jungle 77
Medical Science and Scientism 78

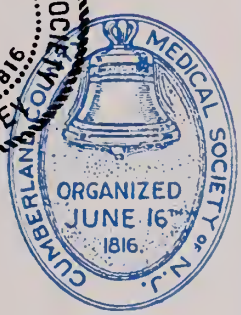
ORIGINAL ARTICLES
Treatment of Animal Bites
Roscoe P. Kandle, M.D., Trenton 79
Short Term Group Psychotherapy
Edgar L. Cook, M.D., Belle Mead 83
A Cystic Duct Syndrome
Norman N. Kohn, M.D., Cinnaminson 86
Lymphangioadenography in Malignant Disease
Garrett M. Keating, M.D., Plainfield 89
Screening of Hearing in School Children
Aris M. Sophocles, M.D. and Robert A. Muzzarelli, Trenton 92
An Effective Bowel Evacuant
Arthur J. Statman, M.D., Irvington 95

STATE ACTIVITIES
Chairmen of Committees and Councils 88
Doctors' Family in Need? 91
Brain-Injured Children Association . . 94
Trustees' Minutes: January 16, 1966 . . 99
Factors Affecting Professional Liability 102
Utilization Review Committees 104
Physicians' Placement 105
Membership Directory . . 36A

OBITUARY 106
BICENTENNALIA 107
ANNOUNCEMENTS 108
LETTER TO THE JOURNAL 109
BOOK REVIEWS 110
RESPIRATORY DISEASE ABSTRACTS 113

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In its bicentennial year, the official seal of The Medical Society of New Jersey shares prominence with the official seals of those component societies celebrating their sesquicentennial anniversaries. According to the proceedings of the New Jersey Historical Society ("An Outline of the History of the Medical Society of New Jersey to 1900"), the first county medical societies organized in 1816 were: Somerset, May 21; Essex, June 4; Cumberland, June 6; Middlesex and Morris, June 11; and Monmouth, July 24.

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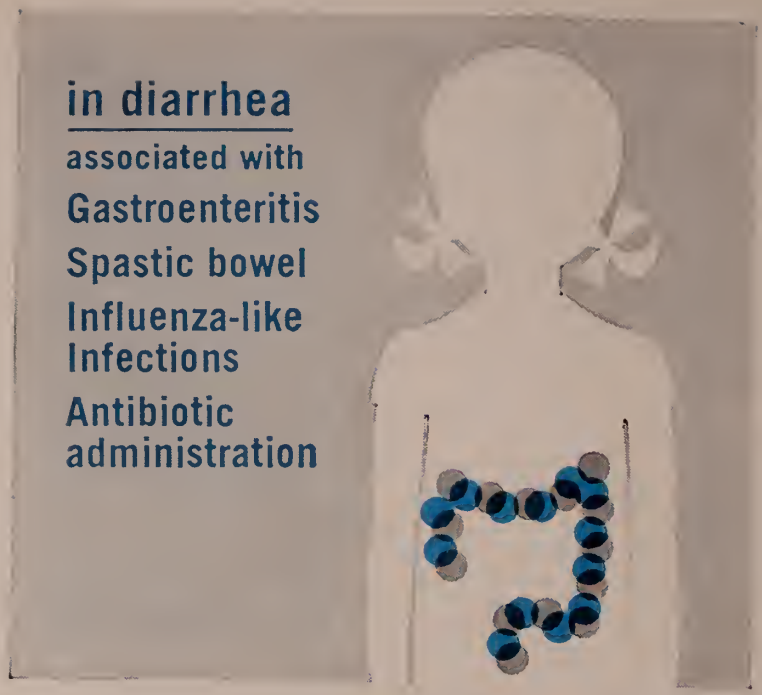
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(Warning: may be habit forming)
atropine sulfate .....0.025 mg.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial *daily dosages*, given in divided doses, until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one fourth the therapeutic dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholinobutyryl-pyrrolidine and Related Amides. Part 1: Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.

2. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.

SEARLE

Research in the Service of Medicine

First aid for a button popper



Second aid for a button popper



By providing combined anorexigenic-tranquilizing action, BAMADEX SEQUELS Capsules help your nonshrinking patients to establish new patterns of eating less. The amphetamine component suppresses the appetite, while the meprobamate helps allay nervousness and tension. And for most patients, the *sustained* release of the active ingredients provides convenient one-capsule-a-day dosage.

Side Effects commonly associated with either component are possible but, to the extent these are dose-related, they should normally be mild and infrequent, since the total dosage of each component on the usual one-capsule-daily regimen is quite low. Also, the sedating effect of meprobamate and the stimulating effect of d-amphetamine sulfate tend, to some extent, to cancel each other out. Adverse effects not peculiar to either component have not been reported. Side effects associated with d-amphetamine sulfate include: insomnia, excitability, increased motor activity, confusion, anxiety, aggressiveness, increased libido, hallucinations, rebound fatigue, depression, dry mouth, anorexia, nausea, vomiting, diarrhea and increased cardiovascular reactivity. Effects associated with meprobamate include: skin rash, nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema, fever and transient leukopenia; also, very rarely, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crisis, anuria, stomatitis, proctitis and anaphylaxis. Other serious effects have occurred after concomitant administration of meprobamate and other drugs. Massive overdosage may produce grave effects.

Precautions: BAMADEX SEQUELS should be given only under close supervision to patients hypersensitive to sympathomimetic drugs, with cardiovascular or coronary disease or who are severely hypertensive; to emotionally unstable persons and to epileptics. Patients should be cautioned not to drink alcoholic beverages while on the drug, and not to drive vehicles if they become drowsy. In all patients kept on the drug for long periods, the drug should be withdrawn gradually to avoid possible serious reactions.

Contraindications: Hyperexcitability, agitated prepsychotic states and a history of previous reactions to meprobamate.

Bamadex® Sequels®

d-amphetamine sulfate (15 mg.) and meprobamate (300 mg.) Sustained Release Capsules

LEDERLE LABORATORIES • A Division of American Cyanamid Company, Pearl River, New York

Lederle

6655



in any language

serpate®

(RESERPINE)

is the number one, first drug for moderate hypertension

As a first step:

SERPATE® (Reserpine) exerts a gradual, sustained reduction of blood pressure

SERPATE® (Reserpine) relieves anxiety and tension in hypertensive patients with low resistance to everyday crises

SERPATE® (Reserpine) is modestly priced

SERPATE® (Reserpine) in low oral dosage is characterized by a minimum of serious reactions and low-yield side effects—thus, it may be used with comparative assurance

SERPATE® (Reserpine) combines readily with more potent antihypertensives for patients exhibiting severe hypertension

Physician samples and technical data sent on request

(Supplied in doses of 0.1 mg. white tablets and 0.25 mg. yellow tablets)

VALE

THE VALE CHEMICAL CO., INC.
PHARMACEUTICALS • ALLENTOWN, PENNSYLVANIA

INDICATIONS: moderate hypertension; labile hypertension, particularly when accompanied by tachycardia or neurosis; and as adjunctive therapy to the more powerful hypotensive drugs in severe hypertension.

DOSAGE: The initial dosage of SERPATE® (reserpine) is 0.5 mg. to 1.0 mg. in divided doses daily. Initial dosage should not be continued more than one week. After one week, the recommended daily dosage is 0.1 mg. to 0.25 mg. An occasional patient will require a maintenance dose of 0.5 mg., but if adequate response is not obtained from this dosage it is well to consider adding another hypotensive agent rather than increase the dosage. Reserpine action is cumulative and maximum response may not be observed until several days to two weeks elapse after therapy is initiated. Slight residual effects may persist for several weeks after discontinuation of therapy. Important: Use SERPATE® (reserpine) with caution in patients with history of mental depression, peptic ulcer, or ulcerative colitis. Members of patient's family should be alerted to watch for and report any symptoms of mental depression.

WARNING: Anesthetics have been found to increase the hypotensive effect of reserpine. Caution should be taken to withdraw patients from SERPATE® (reserpine) two weeks prior to administering anesthetics or to elective surgery. Use with caution in gravid patients. Reserpine passes the placental barrier and may affect the newborn.



Because cerebrovascular insufficiency can be controlled

...help the older patient enjoy life with less confusion, defects in memory, dizziness, weakness, fatigue and decreased activity by maintaining the cerebral blood flow.

Administration and Dosage: Two sublingual tablets three times a day until definite improvement is achieved. This usually occurs within four weeks. Maintenance dosage of one sublingual tablet three times a day is then established to continue this improvement.
Precautions: Hydergine sublingual tablets have not been found to produce serious side effects even in doses far beyond the ones recommended. Some nasal stuffiness due to adrenergic blockade, transient nausea or gastric disturbances have been reported with high dosages.
Supplied: Hydergine Sublingual Tablets, 0.5 mg.; bottles of 100 and 1000.
Composition: Each sublingual tablet contains dihydroergocornine, dihydroergocristine, and dihydroergokryptine methanesulfonates (in equal parts), total 0.5 mg.

HYDERGINE®

SANDOZ



If you can hang on for a few minutes, Doctor, I'm sure I'll start coughing again.

Some patients don't realize there's more to a cough than meets the ear.

If it's the useless, exhausting type of cough that often accompanies respiratory infection or allergy, you can provide prompt relief with Novahistine DH. Its decongestant-antitussive action controls frequency and intensity of cough spasms without abolishing cough reflex. And the fresh, grape flavor of Novahistine DH appeals to children and adults alike.

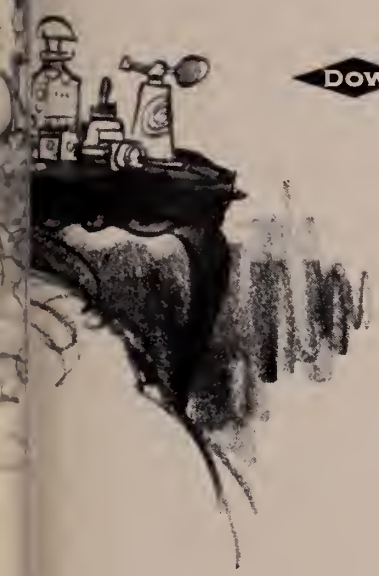
When your diagnosis is bronchitis, complicated by thick tenacious exudates, Novahistine Expectorant is particularly useful. It not only provides decongestive action and controls the cough, but also encourages expectoration, thus easing bronchial constriction and obstruction.

Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.

Each 5 ml. teaspoonful of Novahistine DH contains codeine phosphate, 10 mg. (Warning: may be habit forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, 2 mg.; chloroform (approx.), 13.5 mg.; l-menthol, 1 mg. (Alcohol 5%). Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

NOVAHISTINE® DH

NOVAHISTINE® EXPECTORANT



DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

CONSIDER MONEY

A savings account in the Orange Savings Bank is one of the safest non-fluctuating investments a person can make.

The current interest rate on savngs is 4%—payable and compounded quarterly. Payable from the first day of deposit. (There is no waiting period!)

We have a record of uninterrupted dividend payments over the past 111 years.

For your convenience, transactions may be handled by mail.

Stop to consider it—saving here is your best non-fluctuating investment!

Save at the Oldest Mutual Savings Bank in Essex County

ORANGE SAVINGS BANK

MAIN OFFICE AT MAIN AND OAY STREETS
DRIVE-IN OFFICE AT SO. ESSEX AVE. AND HENRY ST.
MEMBER FEDERAL DEPOSIT INSURANCE CORPORATION

MEDICAL

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EVE
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ASSISTANTS
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trained by physicians for physicians

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Early Requests should be made for July, Sept. & Feb. Graduates.

Our Advertisers Merit Your Support

Not everyone can advertise in this JOURNAL. When you see an advertisement here, you know that the company or service has been stamped as "approved." As you read our advertising pages, you get a compact little course on what's new. And if you tell the company that you saw his notice in these pages, you remind him that this is a happy medium for his service or his company.

DEPROL®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.
Before prescribing, consult package circular.

WALLACE LABORATORIES / *Cranbury, N. J.*

CO-6405

FOR THE



COMPLEX

TRY DEPROL®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

a logical first choice

FOR DEPRESSION

even when complicated by anxiety, tension, insomnia, agitation or rumination.

- **Acts rapidly.**
- **Side effects at recommended dosage infrequent, usually easily controlled.**

WHEN YOUR ELDERLY PATIENTS ASK, *"How will Medicare affect my Blue Shield and Blue Cross Coverage?"* . . . HERE ARE THE ANSWERS:

Since Blue Shield and Blue Cross cannot pay for services that are eligible for benefits under Medicare Parts A and B, it would represent a needless expense to Medicare beneficiaries were their current Blue Shield and Blue Cross coverages continued beyond July 1. They should, of course, maintain their present coverages until that date.

Medicare Parts A and B, while providing some benefits beyond the scope of Blue Shield and Blue Cross, *do not* provide other benefits currently enjoyed by Blue Shield and Blue Cross members.

In order that their 65-and-over members may not lose benefits which they now enjoy, but which are not provided by Medicare, the Plans are offering a special complementary program . . . NEW JERSEY "BLUE CROSS AND BLUE SHIELD 65" . . . that fills important "gaps" in the coverage of Medicare Parts A and B. Here's how it works when added to Medicare Parts A and B:

IN-HOSPITAL BENEFITS

MEDICARE PROVIDES: Up to 90 days of bed-patient hospital care per spell of illness.

UNDER MEDICARE PATIENT MUST PAY: First $40 of hospital costs plus $10 per day co-insurance, 61st through 90th day of hospital stay.

BLUE CROSS AND BLUE SHIELD 65 PROVIDES: Coverage of the $40 deductible and $10 daily co-insurance 61st through 90th day inclusive.

DOCTOR'S SERVICES

MEDICARE PROVIDES: Under Part B, Physician's and surgeon's services in hospital, doctor's office, clinic, home or elsewhere.

UNDER MEDICARE PATIENT MUST PAY: First $50 of charges and 20% of the balance during each calendar year.

BLUE CROSS AND BLUE SHIELD 65 PROVIDES: Coverage of any part of the $50 deductible and the 20% of the balance, for physician's services in hospital.

OUT-PATIENT & OUT-OF-HOSPITAL BENEFITS

MEDICARE PROVIDES: Benefits for out-patient hospital services consisting of diagnostic tests, under Part A, and radiation treatment, splints, casts, and rental of medical equipment under Part B.

UNDER MEDICARE PATIENT MUST PAY: First $20 of out-patient hospital costs and 20% of the balance during each 20-day period of diagnostic testing under Part A, and first $50 and 20% of the balance for physician's services and incidentals under Part B.

BLUE CROSS AND BLUE SHIELD 65 PROVIDES: Coverage of the $20 hospital out-patient deductible and the 20% of the balance for diagnostic tests, and any part of the $50 deductible and 20% of the balance for physician's services in the out-patient department, PLUS coverage for hospital out-patient care for surgery, accidental injury within 72 hours, medical emergencies and specialized therapy.

SERVICES AWAY FROM HOME

MEDICARE PROVIDES: Benefits only in the United States and its territories and possessions except for certain emergency provisions.

BLUE SHIELD®

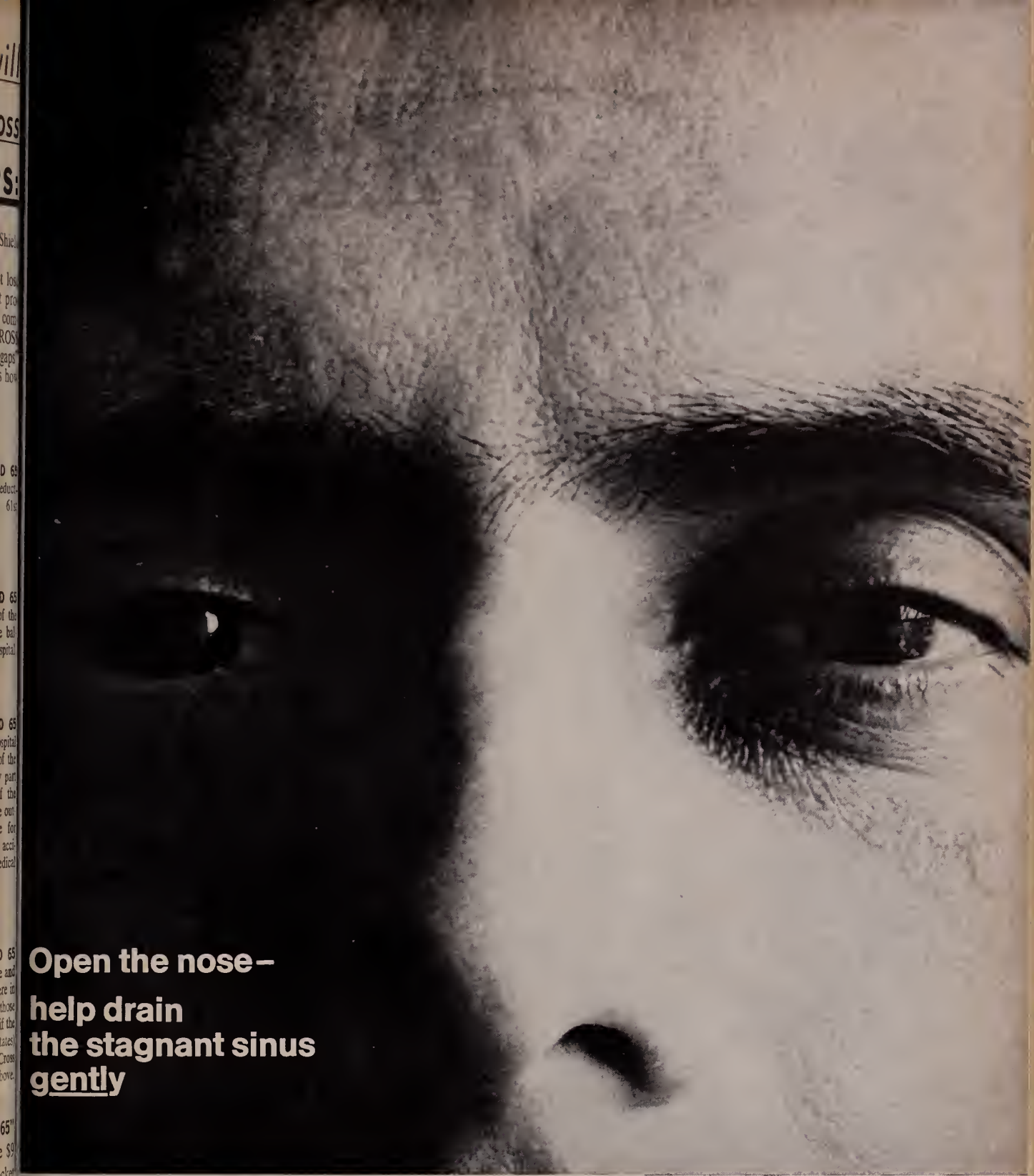
BLUE CROSS AND BLUE SHIELD 65 PROVIDES: Coverage for hospital care and in-hospital physicians' services anywhere in the world. Benefits provided will be those which Medicare would have covered (if the care were rendered in the United States) supplemented by the additional Blue Cross and Blue Shield benefits described above.

Similar complementary programs also are being offered to the Plans' group subscribers aged 65 and over, designed to modify their present coverage to fit in with Medicare.

All Blue Shield and Blue Cross members eligible for Medicare will be changed over to new complementary coverage on July 1. Since the new coverage assumes enrollment in both Parts A and B of Medicare, *it is highly important that eligible persons enroll in Part B,* the voluntary portion for which they must sign up by March 31 and which costs them $3 per month.

NEW JERSEY "BLUE CROSS AND BLUE SHIELD 65" costs $13.50 per quarter per person. Added to the $9 per quarter for Part B, this means a total out-of-pocket cost of $22.50 a quarter, which compares with $28.62 a quarter for present non-group *Blue Shield and Comprehensive Blue Cross.* Additionally, the combination provides full hospital coverage for 90 days per spell of illness, while the present Comprehensive Blue Cross coverage provides 60 days for patients aged 65-70, and 30 days from age 70 on.

P.S.: *If your elderly patient currently has no coverage,* advise him that he may enroll as a new member in NEW JERSEY "BLUE CROSS AND BLUE SHIELD 65," if he has *both* Parts A and B of Medicare, for a well-rounded program of protection.



Neo-Synephrine is a standard among topical vasoconstrictors. It is unsurpassed for reducing nasal turgescence in colds; and a most valuable aid in preventing and treating sinusitis.

Neo-Synephrine stops the boggy feeling of colds at once—works against factors that induce sinusitis. With Neo-Synephrine nose drops, spray or jelly, turbinates shrink on contact, obstructed ostia open and drainage is re-established.

In sinusitis, Neo-Synephrine helps to promote drainage and hasten recovery.* Used promptly, it helps clear the stagnant sinus and lessen the chances of chronicity.

Neo-Synephrine HCl is available in:
1/8% solution for infants
1/4% solution for children and adults
1/4% pediatric nasal spray for children
1/2% solution for adults
1/2% nasal spray for adults
1/2% jelly for children and adults
1% solution for adults (resistant cases)

*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

In colds and sinusitis

Neo-Synephrine® HCl

(brand of phenylephrine hydrochloride)

solutions/sprays/jelly

TOPICAL TREATMENT

TYPICAL RESULTS



PRIMARY PYODERMA



AFTER TREATMENT WITH
'NEOSPORIN' ANTIBIOTIC OINTMENT
AND SALINE COMPRESSES

with 'NEOSPORIN'® brand

Polymyxin B-Neomycin-Bacitracin

ANTIBIOTIC OINTMENT

Each gram contains:

'Aerosporin'® brand Polymyxin B Sulfate ..... 5,000 Units

Zinc Bacitracin ..... 400 Units

Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base) ..... 5 mg.

Tubes of ½ oz. and 1 oz.

- clinically effective
- comprehensive bactericidal action against most Gram-negative and Gram-positive organisms, including Pseudomonas
- rarely sensitizes

For the eradication of infectious organisms in a wide range of dermatologic disorders: impetigo, ecthyma, pyodermas, sycosis vulgaris, paronychia, traumatic lesions, eczema, herpes and seborrheic dermatitis. Prophylactically, for protection against bacterial contamination in burns, skin grafts, incisions and other clean lesions, abrasions and minor cuts and wounds.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Contraindication: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.



mood elevation

Abbott
Anorectic
Program

DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.



controlled release

Abbott
Anorectic
Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

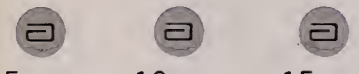
That's why the Gradumet provides controlled-release as well as long release.

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

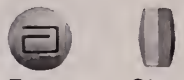
Abbott
Anorectic
Program

DESOXYN Gradumet
Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



Front Side

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium



Front Side

samples available



Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.



economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

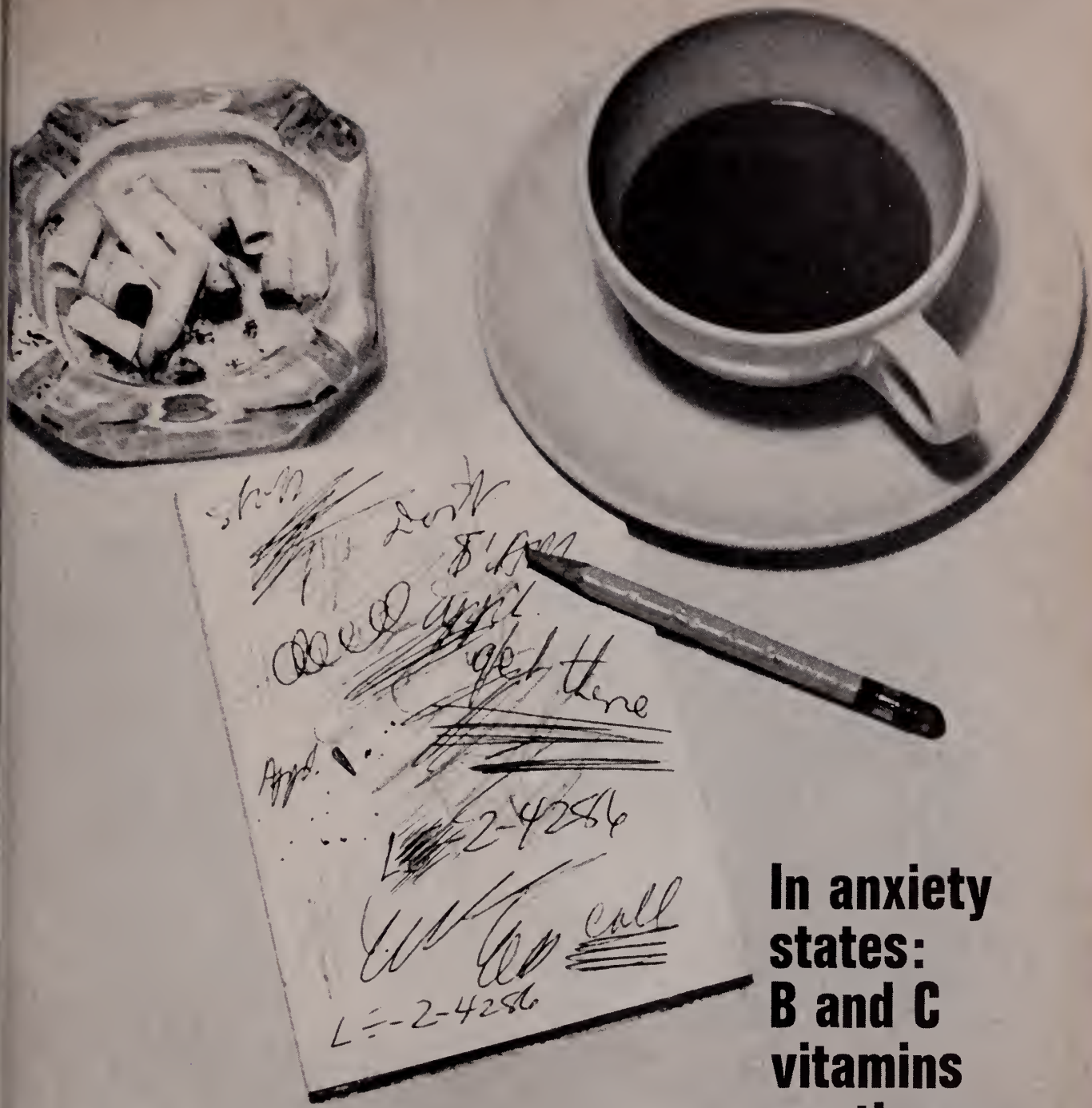
CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

ABBOTT

Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
Sucaryl—Abbott brand of low and non-caloric sweeteners.

601060



In anxiety states: B and C vitamins are therapy

Stress formula vitamins are an important supportive measure in maintaining the nutritional status of the emotionally disturbed patient. With STRESSCAPS, B and C vitamins are present in therapeutic amounts to meet increased metabolic demands. Patients with anxiety, and many others undergoing physiologic stress, may benefit from vitamin therapy with STRESSCAPS.

STRESSCAPS®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

8241 4



Low host resistance?

Consider the "extra" antibacterial activity of Ilosone®

Occasionally, therapeutic failure is due to the patient's inability to mobilize his defenses sufficiently to overcome infection. Typical of this is the debilitated patient, the premature infant, or the diabetic. It is in these patients that the high levels of antimicrobial activity of Ilosone are especially useful. Ilosone has demonstrated antibacterial levels two to four times those of erythromycin base or stearate. Furthermore, it attains them earlier and maintains them longer. Even the presence of food does not appear to affect the activity of Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Dosage: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

Available in Pulvules®, suspension, drops, and chewable tablets. Ilosone Chewable tablets should be chewed or crushed and swallowed with water.

Ilosone®

Erythromycin Estolate

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana. 501280

Lilly

EDITORIALS

In Our Journal Fifty Years Ago

Here, in our bicentennial year, is an editorial from this JOURNAL, published during our sesquicentennial: in the March 1916 issue. Although advertisements of today are more subtle (and no one dares say that they "bring in sales and business") the logic of the 1916 editorial still applies.

Advertising no longer consists of a jumble of words and list of articles for sale. Advertising has become an art and has developed experts who devote hours of time in preparing copy and conveying a message direct to the reader. Advertisements are silent salesmen that appeal to the possible new customer or consumer. As such they are paid a monthly salary in the form of a rate charged for the space they occupy in the given publication. The firms employing these silent salesmen expect that the money thus expended will bring them returns just as they expect the store salesmen to produce results in return for the salary they are paid. The salesman who doesn't sell goods is removed from the payroll. The advertisement — silent salesman — that does not sell goods is likewise discontinued.

This is what we wish to impress upon our members and readers. The advertisements in each issue are absolutely necessary for our publication's financial welfare. Without them we cannot print the JOURNAL. They are not donations. The advertiser expects they will bring him "sales" and business. If they don't, he is going to order their discharge.

We accept none but honest advertisements from honest dealers. Our readers may depend on them. They are your patronizing friends and are deserving of your patronage. They offer you constantly articles that you use and consume in your daily work. They are entitled to your business. By perusing our advertising pages from month to month, much information may be gained and bargains obtained in the supplies you need. Suggestions contained in some of these advertisements are bound to be of value to you. Every issue contains some message to every reader. To this end then, we are urging that you grasp these occasions for securing personal profits. By so doing you will enable your Publication Committee to continue these advertising contracts, secure additional ones, and thus continue the standard of our publication.

(From the March 1916 *Journal*)

Compass And Pathfinder Through The New Drug Jungle

We appreciate the many new drugs dreamed up by the biochemists and pharmacologists and produced by the manufacturers. They make alembics today that no emperor could have bought a decade ago. They save lives and ease the burden of living.

But we suffer from an embarrassment of riches. Who shall tell us which tranquilizer produces the most tranquility and least hypotension? Which antibiotic is the most bacteriostatic and the least hazardous? So many new preparations have appeared since 1955 that (except for the few of us who received our MD's in the last decade) we have to prescribe many drugs that didn't even exist when we went to medical school. One common source of information is the manufacturer's representative* who comes prepared to tell us all about the virtues of his particular brand and who (with fine self-restraint and inherent courtesy) says nothing to downgrade the brand put out by his competitor (except maybe to roll his eyes when the competition is mentioned). As estimable as these representatives are, they can hardly expect to be without built-in bias; and, of course, they are not physicians. We can get some help from reference works on

* Not "detail man," please.

the newer drugs; but in many of these, the monographs are supplied by the manufacturers.

Now comes to our rescue *New Drugs-1965*. Published by the AMA, written by experts, this fat guide tells us volumes about each new (i.e., since 1955) drug. When it comes to side-effects and contra-indications, *New Drugs* lays it on the line. In 46 chapters it covers almost 300 monographs. All this for only $5!

New Drugs replaces the old "NND" which for so many years filled a real need. However, "NND" had a pharmacologic orientation, while *New Drugs* is targetted at the practitioner. (See "Book Reviews," page 110.)

Here at last is an objective compass and pathfinder through the lush growth of new drugs that has characterized the mid-twentieth century.

Medical Science And Medical Scientism

Although many dictionaries don't recognize it yet, the word *scientism* is now being used in a pejorative sense. It identifies a dehumanized scientific method that squeezes compassion and moral aims out of scientific activity. In the past two decades, medical schools have increasingly emphasized the basic sciences. In the same intervals (and probably not by coincidence), there has been a visible decline in the image of the physician.

It is, perhaps, time to take a second look at the implications of a too scientific tincture into our thinking. One would as soon be against science as to be in favor of sin. Yet, consider what A. N. Whitehead once said: that some people elect a scientific career because they don't want to be too involved with life. In the world of the scientist, there appear to be five credos. One is that objectivity must be preserved at all costs. A second is that the scientist as such is unimportant: only his work and his accomplishments are. A third dogma is that the scientist must be unconcerned with the moral or "policy" effects of his work. A fourth is that one should show contempt for inefficiency. Finally, there is the demand for a special—almost overprivileged—status for the scientist. The typical example would be the scientist who invents poison gases or atom bombs with no regard to their uses—since this would require a subjective value judgment—and therefore be of no interest to the true scientist.

This might assure us a deeper knowledge of the pH of the blood, of the diffusive potentials of intercellular fluid, and of the role of the butylene oxidic ring in carbohydrate metabolism. But if the learned doctor who masters all this is disinterested in sick people, devoid of compassion, and uninvolved in human morality—then this is scientism, not science. The scientist's curious unwillingness to look into his own emotional and mental operations gives support to Whitehead's suggested reason for choosing a scientific career.

There is danger that medical education will be enchanted by the trappings of scientism. In his recent report on medical education, for instance, Coggeshall* points out that by the application of new scientific methods, the modern doctor can accomplish more than could the physician "of two decades ago who devoted many weeks of constant care to his patient. No amount of attention insured recovery in the past." Coggeshall looks for "increasing power to manipulate the material events in living systems." He reminds us that modern medical research is becoming increasingly reliant on efforts involving "the microbiologist, the physicist, and the mechanical engineer."

It would seem safer if the scientist who has "increasing power to manipulate the material events in living systems" would also operate within a framework of morality, humility, and personal involvement with human life.

* Coggeshall, L. T., M.D.: Planning for Progress. Report to Association of American Medical Colleges. Evanston, Illinois (April 1965).

ORIGINAL ARTICLES

Doctors are expected to know — but often don't — the immediate management of animal bites. Here is a ready reference refresher.

Treatment Of Persons Bitten By Animals

Roscoe P. Kandle, M.D.*/Trenton

Confirmation of rabies in a bat captured in New Jersey in 1960, seven bats in 1961, ten in 1962, sixteen in 1963, eighteen in 1964, and 21 bats during 1965 establishes the presence of rabies virus in our state. This accentuates the importance of swift and effective treatment of humans bitten by animals. The following information is offered for the guidance of physicians.

Reporting Animal Bites

Under Revised Statutes 26:4-79, 80, and 81, the name, age, sex, and precise location of any person bitten by any animal must be reported to the local board of health by the physician attending the person bitten, by the parent or guardian of a child bitten, or by an adult bitten when no physician attends.

It is expected that investigation to determine the exact circumstances of exposure will then be conducted by the local health department of the municipality in which the bite occurred, in which the person bitten resides, and in which the animal is maintained.

Consultation will be provided by the State Department of Health. The Department will conduct such investigations if qualified local health persons are not available.

The Biting Animal

Any animal which bites a person should be caught alive if possible, dead if necessary. The live animal is confined for at least ten days in an enclosure suitable to prevent escape. Local boards of health have authority to confine an animal which has attacked or bitten a person. Confined animals should be observed by a veterinarian to detect signs suggestive of rabies. If an animal is confined by some person *not* qualified to detect such symptoms, the animal should be examined at once by a veterinarian if it shows any of the following: a change in disposition, unusual "nervousness" or irritability, a tendency to bite without provocation, a change in voice, dropping of the lower jaw, weakness of the legs, anorexia, or twitching of muscles.

Submission Of Brain For Laboratory Examination

If any animal which has bitten a person dies within ten days of the bite (or is killed during capture), the head should be delivered by messenger to the laboratory of the State Department of Health in the circular building next to the Health-Agriculture Building on John Fitch Way, Trenton. The messenger will get directions from the clerk in the lobby

* Dr. Kandle is the New Jersey State Commissioner of Health. This article is an updating of one published in our January 1962 *Journal*, 59:14.

GUIDE FOR SPECIFIC POST-EXPOSURE TREATMENT

ADAPTED FROM WORLD HEALTH ORGANIZATION GUIDE

Nature of Exposure	BITING ANIMAL*		Recommended treatment (in addition to local treatment)
	At time of exposure	During observation period of 10 days	
I. No Lesion: Indirect Contact	Robid	--	None
II. Unprovoked Bites (1) mild exposure	a. Healthy	Healthy	None
	b. Healthy	Clinical signs or proven rabid	Start vaccine at first clinical signs in animal.
	c. Signs suggestive of rabies	Healthy	Start vaccine immediately. Stop if animal is normal on 5th day after exposure.
	d. Presumed rabid, escaped or unknown		Start vaccine immediately
	e. Killed	--	Start vaccine immediately.*** Discontinue with negative lab. report.
	f. Bat	--	Vaccinate regardless of lab. result.
(2) Severe Exposure (multiple, or face, head or neck bites)	a. Healthy	Healthy	None
	b. Healthy	Clinical signs or proven rabid	Start serum and vaccine at first sign of rabies in biting animal.
	c. Signs suggestive of rabies	Healthy	Serum immediately followed by vaccine; vaccine may be stopped if animal is normal on 5th day after exposure
	d. Presumed rabid, escaped or unknown	--	Serum immediately followed by vaccine.
	e. Killed	--	Start vaccine immediately.*** Discontinue with negative lab. report.
	f. Bat	--	Vaccinate regardless of lab. result.
III. Bites where Provocation Exists	a. Healthy	Healthy	None
	b. Healthy	Clinical signs or proven rabid	Start vaccine at first signs of rabies in animal.
	c. Signs suggestive of rabies	Healthy	Start vaccine immediately. Stop if animal is normal on 5th day of exposure.
	d. Escaped or unknown	--	None.**
	e. Killed	--	None, unless lab. reports evidence of rabies.
	f. Bat	--	Vaccinate regardless of lab. result.

*Rats, mice and hamsters appear to be of very little importance as transmitters of rabies in this area. Persons bitten by these animals should not receive specific post-exposure treatment, unless the reported activities of the animal are so distinctly unusual as to be highly suggestive of rabies.

**This recommendation is predicated on the fact that the incidence of rabies in New Jersey is so low that the possibility of adverse effects from vaccination outweighs the risk of rabies. In the event there is a change in the incidence of rabies in this State, all physicians will be so notified and recommendations appropriately modified.

***Physician may elect to delay administration of vaccine if animal brain can be delivered promptly to laboratory.

New Jersey State Department of Health

Figure 1.

of the Health-Agriculture Building during business hours; or from the watchman at other times. Responsibility for delivery of animal heads to Trenton rests, in order, with: *first,* the owner of the biting animal; *second,* the person bitten or a member of his family, *third,* the Local Board of Health. Rabies' funds are available in every municipality from the sale of dog licenses. These funds may be used to aid in meeting the costs of transporting specimens. State Police are not normally to be expected to transport specimens.

The prompt examination of *any* specimen is a necessity; in rabies, it is of extreme importance. Make every effort to have the specimens submitted as quickly as possible. The State Department of Health will cooperate by having prompt examination made on a daily basis. Time is critical. The recommendations for antirabies serum are that if it is indicated, it should be used within 72 hours.

Bats

The bat is the exception to the rule regarding ten-day confinement of biting animals. Bats may live more than ten days after the virus is present in the saliva. A ten-day confinement period may give a false impression that the bat could not have transmitted rabies at the time of the bite. The biting bat should be delivered to the laboratory in a jar, or similar container, in which it can be destroyed while at the laboratory.

Post-Exposure Treatment

Early, vigorous, local cleansing is of primary importance in preventing infection. Wash the wound thoroughly with soap or detergent and flush thoroughly with water. The wound should *not* be immediately sutured, unless this is strongly indicated as part of necessary surgical procedures. If the recommended treatment includes the use of antirabies serum, part of the serum dose should be infiltrated about the wound. Apply antiseptic after the foregoing procedures. Cauterization is not usually recommended. If the physician feels that tetanus prophylaxis is indicated, it should be instituted by the use of a booster dose of tetanus toxoid.

The table presented on the opposite page outlines recommendations of the New Jersey State Department of Health for specific post-exposure treatment.

The manufacturer's recommendations should be consulted prior to use of serum and vaccine.

Antirabies serum, if used, should be administered as soon as possible, preferably within 72 hours of exposure. Antirabies serum should be administered in a dose of 40 international units per kilogram of body weight.† Sensitivity of the patient to the serum should be tested before it is used. A portion of the dose should be infiltrated around the bite. Under no circumstances should additional serum be administered. Subsequent doses may interfere with the response to rabies vaccine.

Duck embryo rabies vaccine is prepared for subcutaneous injection in doses of one cubic centimeter daily for 14 days. If serum is followed by a full course of vaccine, two supplemental doses of vaccine should be administered at 10 and 20 days following completion of the usual vaccine schedule.

Procurement Of Serum

Physicians may obtain antirabies serum from the Warehouse of the State Department of Health in the Health-Agriculture Building, John Fitch Plaza, Trenton. A written order from the physician is required. Arrangements may be made by calling one of the following listed individuals:

	Business Hours	*Other Times*
Mr. Lyle Cook	609-292-5570	609-882-1944
Dr. William J. Dougherty	609-292-4046	609-396-6067
Mr. Edward A. Osvai	609-292-5514	609-799-1130

Procurement Of Vaccine

Rabies vaccine may be obtained from the Warehouse of the State Department of Health as described above, and from the biological distributing stations that follow.

† 18 units per pound of body weight.

BIOLOGICAL DISTRIBUTING STATIONS

Location	Address	Telephone No.
Atlantic City	Board of Health Municipal Building	609-344-2121
Asbury Park	Board of Health Asbury Avenue and Main Street	201-775-0196
Bloomfield	Board of Health Municipal Building	201-748-0500
Camden	Department of Health Municipal Building	609-964-9000
East Orange	Board of Health 143 New Street	201-673-4100
Elizabeth	Board of Health Municipal Building	201-353-6000
Hackensack	Hackensack Hospital	201-487-4000
Hackettstown	103 Little Street (Mr. William Greenham)	201-425-4443
Haddonfield	State Health District 89 Haddon Avenue	609-429-7550
Jersey City	Board of Health, "B" Floor Surgical Building, Medical Center	201-432-3273
Long Branch	Board of Health Garfield Court	201-222-7000
Morristown	Board of Health 29 Ann Street	201-538-3707
Newark	Board of Health Plane and William Streets	201-624-6400
North Arlington	Board of Health Municipal Building	201-991-4367
Paterson	Board of Health Mill and Passaic Streets	201-278-2110
Perth Amboy	Board of Health 44 Market Street	201-826-0290
Plainfield	Board of Health Municipal Building	201-756-0704
Somerville	Somerset Hospital	201-725-4000
Trenton	State Department of Health John Fitch Way Plaza (Mr. Lyle Cook)	609-292-5570 (home) 609-882-1944
Trenton	State Department of Health John Fitch Way Plaza (Dr. William J. Dougherty)	609-292-4046 (home) 609-396-6067
	State Department of Health John Fitch Way Plaza (Mr. Edward A. Osvai)	609-292-4023 (home) 609-799-1130

P.O. Box 1540

Short term group psychotherapy has been useful in diagnosis, treatment, and management of patients in an intensive care psychiatric program.

Short Term Group Psychotherapy*

Edgar L. Cook, M.D./Belle Mead

With intensive care, many acute psychiatric illnesses (which formerly would have required long periods of hospitalization) can be returned to the community in a short time. The Langley Porter Clinic[1] reports the average duration of hospitalization for anxiety reactions is three weeks; for depressive reactions, five weeks; and for schizophrenic reactions, six weeks. In general, similar experience has been recorded at the Carrier Clinic where the average period of hospitalization for 1554 patients (representing all conditions) was 27 days for 1964. This does not imply that *all* persons can be discharged within this period; nor that they are cured. However, they have achieved maximum hospital benefit or remission so they can be treated in the community and can be returned to their families and gainful employment. Early return helps to overcome much of the stigma associated with hospitalization for a "nervous disorder."

With shorter periods of hospitalization, what will be the role of group psychotherapy? Some therapists believe that twelve to fifteen sessions are needed to develop progress with a group. If so, is there any place for short term group psychotherapy during hospitalization?

Short term group psychotherapy should not be confused with group discussions conducted by non-professional personnel even if that process *is* labelled "group psychotherapy." Nor should it be confused with (nor be used to deprecate) the benefits gained from "social" groups like Alcoholics Anonymous. Finally, it must not be confused with intake groups where a whole ward (twenty to forty patients) meet to discuss primarily administrative or hospital adjustment problems.

Group therapy sessions at the Carrier Clinic are conducted by one of the staff psychiatrists with experience, training, and interest in that field. Short term inpatient group psychotherapy is never undertaken by any person with limited training or experience in individual psychotherapy. This is because there are diagnostic components, multiple transference problems, and much hostility directed to the therapist. It is a difficult but challenging type of therapy. Unless handled effectively, it can discourage a patient about participating in group therapy after his discharge from the hospital.

Hospitalized patients in our groups are usually under the care of the same psychiatrist for all phases of treatment and management; although, at times, patients under the care of another psychiatrist are included in a group. In short term hospitalization it is usually more effective to have the same psychiatrist doing both the individual and the group therapy. Having admitted the patients, this doctor has the history directly from the patient and relatives. In such a position, he is able to discuss in individual therapy those topics which develop in group, rather than relate these to another psychiatrist to discuss in an individual session.

* This work is from the Carrier Clinic, Belle Mead, New Jersey.

Patients are selected for group therapy from all diagnostic categories. A patient will not be admitted to the group if the psychiatrist thinks that he will not benefit from such therapy or if he is so acutely psychotic as to disrupt the group. Some therapists believe that to facilitate "movement," selection should be by a single diagnostic category. Thus, they would not place schizophrenics in a group with neurotics. Many groups throughout the country are selected on the basis of residence or some special category. There are reports of groups for multiple sclerotics, mothers of epileptics, delinquent girls, non-alcoholic wives of alcoholics, incarcerated sexual deviates, mothers with infanticidal wishes, those with orthopedic problems – to list only a few of the many special categories considered suitable for group therapy.

Our groups are limited to seven or eight members each. More than that would limit interaction. This is particularly true in short term group psychotherapy. Our groups are open-ended with new members being introduced as others are discharged from the hospital. Group therapy does *not* replace individual therapy, drug therapy, or electric shock therapy when indicated. This is explained to each member, who is advised that this is only a part of the total treatment and that group therapy is not prescribed for every patient. The selected patient is told that he has been offered this opportunity because of the benefits we expect him to derive from this program. We have experienced very little resistance to group therapy. The sessions are for an hour, three times a week. Most patients start immediately after admission, although some who are acutely disturbed begin at a later date. Each new member is asked to introduce himself and (in a few sentences) to describe the condition that brought them to the Clinic. Discussions are open but must be limited to relevant problems. There is no established format but the discussion often leads to such subjects as hostility, resentment, anger, guilt, love, acceptance or rejection, and problems of adjustment after leaving the Clinic.

Many individuals who have difficulty with interpersonal relationships and identification with peers find that in a group they are less threatened than they are by authoritarian figures in individual therapy. The interaction in group can be helpful in individual sessions by discussion and comparison with group and interpersonal relationships outside the hospital. Some need to discharge hostility in a permissive atmosphere; e.g., when the hostility is directed to the therapist, other members can often help explore the dynamics in a non-threatening manner. One woman who found fault with the Clinic, attendants, nurses, and therapist to the extent that she felt this justified a decision to leave the Clinic the day after admission (against medical advice) brought these angry feelings to the group; after she discharged these angry feelings and was accepted by the group, she decided to remain. Individuals who have avoided group interaction before coming to the Clinic soon find acceptance and begin to feel that groups are not as threatening as they anticipated. Later, they find it easier to seek group relationships after leaving the hospital. Sharing experiences and thoughts helps some to be relieved of the guilt feelings they have had, especially about parents. Discussion of problems in a therapeutic atmosphere reduces anxiety and helps to promote psychological homeostasis.

Group therapy often helps prevent premature discharges. After a brief inadequate period of treatment some individuals feel they are ready to leave the Clinic; however, discussions by the group often helps the individual see the unwisdom of such a decision. Occasionally a member of the group does leave prematurely; only to relapse and be readmitted. The advice of such a patient supported by the group creates strong pressure on the uncertain individual to remain until the doctor says that he is ready for discharge.

Short term group therapy can be diagnostically helpful, especially with "pseudoneurotic" schizophrenia and with masked depressions. For example, one woman in her early forties who had been active in social affairs and had a good personality adjustment developed a

problem with alcohol. After treatment in another institution for several months without success, she was transferred to the Carrier Clinic. Following admission she presented a pleasant and charming appearance in her adjustment with others and at individual sessions; however, in group sessions, depressive symptoms became evident. Following a course of electric shock treatment, these disappeared; and with psychotherapy, she regained self-confidence. Now over a year later she has not returned to alcohol and has regained her customary social adjustment. Observation of group interpersonal relationships often aids in the diagnosis of "pseudoneurotic schizophrenia"; such individuals may have been treated with minor tranquilizers to relieve anxiety. Actually they benefit more from a phenothiazine medication. With proper diagnosis, psychotherapy can be modified to be of greater benefit to these individuals.

Group psychotherapy offers one more modality to observe progress directly. This is important in intensive treatment where the therapist needs to change or modify therapy when the patient is not making satisfactory progress. Some individuals having great fear to electric shock therapy are able to discuss it with individuals in the group who have benefited. Thus they can more readily accept the necessary treatment. In my experience, group therapy seems to have more impact and meaning in this area than any individual discourse could ever offer.

Another benefit, though indirect, occurs with the informal and relaxed hour in group therapy. These patients look forward to this time with their doctor. Although sessions are therapeutically oriented, an occasional administrative problem is introduced which can create group anxiety regarding a situation or incident. A few moments devoted to support and reassurance does much to dispel these feelings. When the individual introduces a personal matter (which would impede group interaction) it is deferred until after the session.

Many initial resistances of outpatients to group psychotherapy can be eliminated when introduced to a group as an inpatient. Many patients leave the clinic with a positive motivation for continued group therapy, and when our psychiatrist offers this to the referring physician responsible for post-hospital care this is frequently accomplished with the cooperation of the referring physician.

In a comprehensive community mental health center, short term inpatient group psychotherapy can help with diagnosis, treatment, and selection of suitable candidates for outpatient group psychotherapy. Two years ago, I reported the use of an intake group for screening individuals expressing motivation for the therapy in a military situation.[2] Such a procedure aided considerably to eliminate many poorly motivated for constructive therapy but primarily interested for environmental manipulation. After a few sessions in an intake group, positively motivated individuals were transferred to one of several stable groups. This reduced the dropout rate in permanent groups. Abrahams and Enright[3] reported the use of groups alone for psychiatric intake in an outpatient clinic. They found that patients could be seen much earlier following application. In comparing the dispositional status with others (seen in traditional individual intake), no significant differences were found in "no-show" or "drop out rates" of numbers still in treatment after six months. If group therapy is used as part of the intensive treatment as an inpatient, many of these difficulties could be eliminated.

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Carrier Clinic

Recurrent right upper abdominal pain may be due to biliary disease, but not necessarily to gallstones. Dr. Kohn here reports a relatively obscure syndrome.

A Cystic Duct Syndrome*

Norman N. Kohn, M.D./Cinnaminson

Recurrent episodes of right upper abdominal pain in the presence of biliary disease naturally suggest gallstones. There are, however, some unusual structural abnormalities of the cystic ducts which, in the absence of gallstones, can produce a similar symptomatic picture. The abnormality here described is known variously as narrowing of the duct, choledochostenosis, or — in Cozzolino's simpler term[2] — "cystic duct syndrome." Although well known and often reported in Europe and South America, this syndrome is seldom cited in the American medical literature. Here is a typical case.

A 47-year-old man was admitted to the Medical Service at Rancocas Valley Hospital, Willingboro, N.J. for recurring episodes of right upper quadrant abdominal pain. He had had these for 15 years. Episodes of pain lasted for from 8 to 24 hours, with clusters of such episodes for four or five day periods several times every year. Pain was of such severity as to cause interruption of his work for several days at a time, requiring meperedine administration for relief. By observation, he had learned that certain foods were predictably capable of inducing an attack of pain. These included fried foods, pork, nuts, and chow mein. At other times, however, pain followed ingestion of otherwise innocuous foods.

Oral cholecystography had been done many times for suspected gallstones. These studies were always normal except for poor contractility of the gall bladder following ingestion of the fatty meal. Of interest is the fact that such a meal had preceded an attack of abdominal pain lasting several hours on two occasions. The previous medical history included mild gout for five years, well controlled with colchicine and probenecid. A recurring low back disorder had been ascribed to a herniated disc.

A meticulous physical examination on admission to the hospital, and again during an attack of pain, were both normal except for right upper quadrant abdominal tenderness. This was more intense at end-inspiration. The gall bladder could not be palpated at any time.

The abdominal pain subsided gradually 12 hours after this admission, but it took several injections of meperedine to give him relief.

An entire gamut of x-rays and laboratory tests was done; and except as indicated below, they were all normal. The oral cholecystography needs special mention. This x-ray demonstrated good visualization of a gall bladder normal in size, shape, and position. No calculi were visualized in the gall bladder. The cystic duct was not seen. After the administration of the usual fatty meal, contractility of the gall bladder was listed as "less than usual." Within 15 minutes of the administration of the fatty meal, the patient experienced sudden right upper quadrant abdominal pain radiating to the right scapular area. He told us that the pain so induced was identical with his spontaneously occurring attacks. Physical examination at the time of the pain was normal except for profuse diaphoresis and abdominal tenderness similar to that noted on admission. Pain subsided 12 hours later.

Study by intravenous cholangiography on the following day showed the hepatic and common ducts to be narrower than normal. No calculi were seen. The gall bladder was still well visualized from the previous day's cholecystography.

The most likely explanation for the patient's symptoms was that of partial cystic duct obstruction due to kinking or fibrotic stenosis, causing attacks counterfeiting biliary colic. Evidence to sustain this conclusion included the following: recurring pain episodes in the distribution usually attributed to biliary tract disease; precipitation of pain by fatty foods and the fatty meal of cholecystography; absence of demonstrable calculous disease of the gall bladder on x-ray; impaired contractility of the gall bladder; small calibre common duct on intravenous cholangiography.

Cholecystectomy was recommended and was done.

At surgical exploration, the gall bladder was grossly normal. The surgeon found the common duct to be narrower than normal, though not otherwise noteworthy by palpation or visualization. The cystic duct wall was thickened. Its lumen was very narrow, and it would not admit the smallest sized catheter for an operative cholangiogram. Cholecystectomy was done. No other abnormalities of the abdominal viscera were noted.

Pathologic examination of the resected gall bladder was grossly normal, but microscopy showed infiltration of the wall with inflammatory cells. This suggested a subsiding cholecystitis. No calculi were seen. The most striking abnormality was seen in the cystic duct. Here, the wall was markedly thickened with encroachment upon an abnormally small pinpoint lumen. No stones were present.

Microscopic examination of the wall of the cystic duct showed thickening of the wall due to large bundles of muscular and connective tissue. Moderate inflamma-

* From the Division of Medicine at the Rancocas Valley Hospital, Willingboro, N.J.

tory reaction was interspersed between hyperplastic ducts and glandular elements. The pathologic diagnosis was cystic duct stenosis with fibrosis, and subsiding cholecystitis.

His postoperative course was smooth, and he was discharged six days after the surgery. He was conscientiously followed up for the next 6 months. He reported that for the first time in 15 years he had gone that long without abdominal pain. He had tried eating the foods which seemed to have precipitated his previous attacks, and he was able to do this with impunity.

Here, the attacks of abdominal pain were certainly suggestive of gall bladder disease. Despite relatively normal cholecystography, cholecystectomy was advised. The pre-operative indication for this procedure under the circumstances might be regarded as somewhat tenuous, but was felt to be dictated by the almost incapacitating nature of the previously unexplained symptomatology. An additional consideration leading to the recommendation for surgery was the strong similarity to previously reported cases (see below) found to have cystic duct disease in the absence of significant gall bladder disease and resembling biliary colic. These had been cured by cholecystectomy.

In this disorder, the clinical picture is that of repeated episodes of upper abdominal pain indistinguishable from biliary colic, but with normal oral cholecystography. In one reported series,[1] 20 per cent of the cases had a narrow common duct as seen on intravenous cholangiography. This finding is present in our case.

The uniform pathologic finding in all reported cases[1,2,3,4,5] is an abnormal cystic duct consisting of fibrosis of the wall or a kinked tortuous configuration of the duct. Biliary calculi are not present. This situation results in partial cystic duct obstruction with a ball-valve effect on bile flow permitting influx of bile into the gall bladder, but with impeded egress of bile from the gall bladder when it contracts. An identical clinical picture has recently been reported[3] in a 9-year-old boy, apparently due to congenital stricture of the cystic duct and leading to chronic cholecystitis.

This syndrome differs from so-called "biliary dyskinesia" by the presence of demonstrable partial obstruction of the cystic duct and by the curative effect of removal of the gall bladder.

Although apparently well-known abroad[1,4,5] and described by a variety of awkward and incompletely descriptive terms, the condition is not yet widely recognized in this country. Recently Cozzolino and associates[2] reported seven patients whose history suggested biliary colic, but who had normal oral cholecystography. All seven were found on surgical exploration to have significant non-calculous disease of the cystic duct causing partial obstruction to bile flow. The observed abnormalities of the cystic duct included adhesions, fibrosis, kinking or acute angulation between the gall bladder and the duct. The general term "cystic duct syndrome" was proposed for this condition. A characteristic of the group was impaired contractility of the gall bladder following ingestion of a fatty meal, a finding present in the case presented here. The diagnostic significance of this in connection with biliary tract disease in adults has been disputed, however, although it may be significant in children.[3] Cozzolino and associates[2] used cholecystokinin stimulation of the gall bladder simultaneous with biliary drainage and thus they demonstrated impaired emptying of the gall bladder in all cases, suggesting this procedure as a diagnostic test for the "cystic duct syndrome."

In the case history reported here, the finding of a cystic duct with fibrotic wall and markedly narrow lumen offered an adequate explanation for the symptoms. The curative effect of the cholecystectomy upon the symptoms is further confirmation of this relationship. This would appear to be an additional instance of the "cystic duct syndrome" as defined by Cozzolino *et al.*[2] Ideally, a cholecystokinin study with biliary drainage might have offered pre-operative confirmation of this condition, but cholecystokinin has not yet become readily available. When this situation is altered, it may subsequently be shown that many more patients with upper abdominal pain have partial cystic duct obstruction than the scarcity of reported American cases suggests.

Summary

A patient with long-standing pain resembling biliary colic is reported. The oral cholecystogram was normal. Partial cystic duct obstruction due to fibrosis was found at surgical exploration, and was considered to be responsible for the symptomatology. Cholecystectomy abolished the symptoms. This "cystic duct syndrome" may occur more frequently than the meagre American literature suggests.

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Wynwood Drive at Route 130

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Chronically Ill and Aging	Matthew E. Boylan, M.D.
Conservation of Hearing & Speech	Warren E. Crane, M.D.
Conservation of Vision	Ralph E. Siegel, M.D.
Credentials	Marcus H. Greifinger, M.D.
Disaster Medical Care	Jack R. Karel, M.D.
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Medical Student Loan Fund	Luke A. Mulligan, M.D.
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Mental Health	Robert S. Garber, M.D.
Occupational Health, Rehabilitation, Workmen's Compensation	Joseph A. Lepree, M.D.
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Public Health	John B. Fuhrmann, M.D.
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Retirement Plan for Physicians	Nicholas E. Marchione, M.D.
Revision of Constitution and Bylaws	Louis F. Albright, M.D.
Traffic Safety	William L. Sprout, M.D.
Woman's Auxiliary Advisory	George O. Rowohlt, M.D.

Here is a really new, safe, and effective procedure in cancer of the female genitalis.

Lymphangioadenography In The Study Of Malignant Disease In Gynecology

Garrett M. Keating, M.D./Plainfield

Evaluation of the pelvic lymphatic system in female genital cancer has recently been improved by the use of lymphangioadenography (lymphography). This procedure involves the injection of a radiopaque material in the distal lymphatics. It results in the radiographic demonstration of the pelvic and periaortic lymph nodes and vessels.

Direct lymphography was first described in 1952 by Kinmonth[1]. Up until that time, lymphatics were indirectly observed by injecting dyes into the subcutaneous tissues, and later by observing them in the lymph vessels. Additional work by Wallace[2], Jackson,[3] and Averette[4] has modified and improved the direct method. Fischer and Zimmerman[5], through their experimental work in dogs, reasoned that roentgenographic visualization of lymph nodes and vessels in humans could be used to detect invasion of lymph structure by neoplasm. Since lymphatic spread is so important in the clinical course of cancer, it seemed appropriate to investigate the diagnostic and, possibly, even the therapeutic value of lymphography in gynecologic cancer.

In this series, 18 patients have been studied by the lymphangiographic technic. All patients were on the service of the Obstetric and Gynecologic Department of the New Jersey College of Medicine at the Margaret Hague Maternity Hospital in Jersey City. The procedure has been of such diagnostic value that it is now a routine part of our oncologic survey.

Materials and Methods

The time required to perform lymphangiography is usually one to two hours. The patient is placed on a stretcher and made as comfortable as possible. Mild sedation or a tranquilizer may also be used.

To identify the lymphatic vessels on the dorsal aspect of the foot, an injection of 0.25 cubic centimeters of a dye-anesthetic solution is made into the interdigital web-spaces of the foot. The solution consists of 1½ cubic centimeters of FD and C Blue Number One, ten per cent dye, and one-half cubic centimeter of one per cent procaine hydrochloride. The lymphatics will absorb the dye in from 30 minutes to one hour. Blue streaks will develop and extend cephalad from the injection sites.

Under local infiltration anesthesia, a small (3 to 4 centimeters) skin incision is made on the dorsum of the foot. The incision should cross several of the blue streaks that radiate cephalad. Care is taken not to cut too deeply into the lymphatic layer. A careful dissection must then be carried out until several small blue-stained lymph vessels are demonstrated in the sub-fascial plane. Massage distal to the incision will fill and distend the lymphatics

and aid in its identification. The lymphatic must also be thoroughly stripped of all excess tissue so that it will be easier to cannulate.

The vessel is then further stabilized with two loose silk ligatures placed proximal and distal to the point of cannulation. A small, narrow-gauge needle (27 to 30) is then placed into the vessel and secured with the proximal ligature. We have found that the use of some form of magnification (jeweler's loop) aids in the cannulation. Polyethylene tubing is then secured by means of adapters to it and to a source of radiopaque material in a 20 cubic centimeter syringe. Our choice for the radiopaque material is Ethiodol® with chlorophyll. We have found that 30 cubic centimeters of the media are adequate for bilateral visualization of the lymph nodes and vessels. The addition of the chlorophyll serves the added purpose of imparting a greenish stain to the lymph glands in the pelvis which aids the surgeon at the time of operation in their localization and excision.

The contrast material is then injected slowly, using a Holter lymphangiogram pump. Average injecting time is approximately one hour. Shorter injecting times (obtained by either warming the contrast media or increasing the pressure) usually cause discomfort.

Following the initial injection of two to three cubic centimeters of the Ethiodol®, portable roentgenograms are taken of the area proximal to the injection site to rule out venous injection or excessive local extravasation.

Anterior, oblique, and lateral roentgenograms of the pelvis and abdomen are taken 24 hours later for best visualization of the lymph nodes. The nodes will remain visible for as long as six to eight months. Barium enema and excretory urogram studies should be avoided immediately prior to lymphangiography so as not to confuse the interpretation of the films with residual contrast media.

Results

Following lymphangiography, the lymph vessels may be observed along the medial aspect of the leg accompanying the greater saphenous vein. Proximal to the knee they will be seen to terminate in the superficial subinguinal and inguinal nodes. From this point, the lymphatics along the external iliac, hypogastric, and common iliac vessels may be observed, as well as the lymph nodes in the obturator fossa. Communications at this level between the right and left common iliac vessels will help outline the sacral lymphatics.

Abdominal roentgenograms will demonstrate the peri-aortic nodes, and the media may be seen entering the cisterna chyli. The thoracic duct may also be visualized and may sometimes be followed through the chest to the point where it enters the left subclavian vein. Chest roentgenograms will reveal a miliary pattern of the contrast material through the lung fields. This is asymptomatic and has no clinical significance.

In the interpretation of lymphangiography, care must be taken in the inguinal and pelvic areas where nodes may appear abnormal because of fibrosis and fatty replacement associated with previous inflammatory disease.

The normal lymph nodes are usually variable in size and shape, averaging 1½ to 2 centimeters in diameter. They are most often oval but may be irregular in shape. Each has a distinct margin with an indentation at the hilus and an internal homogenous reticulogranular pattern.

The two most important causes of variation in nodal pattern are inflammation and metastatic disease. Inflammatory lymph nodes are usually larger in size and frequently greater in number but appear to maintain their normal contour and architecture. In metastatic disease, however, the nodes have irregular margins with uneven filling defects producing a "moth-eaten" appearance. When a node is partially replaced by tumor, only the normally functioning portion will be seen. With complete replacement by tumor, the nodes will not be seen. False positive findings are sometimes noted when inadequate filling is due to

technical difficulties or fibrotic changes secondary to previous surgery or radiation. These must be watched for and carefully studied.

In our series, we have had no major complications. An occasional patient has developed a mild lymphangitis but these have responded to leg elevation and heat. Strict aseptic technic will minimize wound infection at the cutdown site.

The possibility of pulmonary embolization must be considered and can usually be avoided by radiographic confirmation of the intralymphatic injection. To date, no deaths from pulmonary embolus following lymphangiography have been reported. In our series, the one patient who did develop a pulmonary embolus later gave a history of severe traumatic injury to her left leg as a child. Later, roentgenographic examination of the lymphatics in this leg was suggestive of a lymphatic-venous anastomosis.

Discussion

Lymphangiography offers an added diagnostic procedure to the problem of detecting lymph node metastases in the absence of other signs of metastatic disease.

Of equal importance is the role that the chlorophyll-containing media has played with regard to lymphadenectomy. Following the use of this agent, the lymphatics are clearly identified and dissection is not only easier but obviously more complete. Postoperative roentgenograms also will allow the surgeon to evaluate the thoroughness of the dissection.

It is in the field of therapeutics that the real value of this procedure may be obtained. The intralymphatic infusion of either large doses of chemotherapeutic agents[6] or radio-isotopes[7] has been tried by some and with moderate success. However, the fact that carcinomatous tissues contain little or no lymphatics, as seen by lymphangiograms, may limit the value of this procedure.

Summary

1. Lymph node spread remains the most frustrating aspect of genital cancer therapy.

2. Lymphangiography is a new approach to the anatomy, physiology, and pathology of the lymphatic system and affords vast clinical and therapeutic potentials.

3. The procedure has been done on 18 patients at our institution and is now a routine feature of our oncologic evaluation.

4. Procedural methods, interpretive hazards, and complications are described.

5. Diagnostic value, improved lymphadenectomy, and therapeutic potentials are discussed.

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1. Kinmonth, J. B.: *Clin. Science,* 11:13 (1952)

2. Wallace, S.: *et al, Radiology,* 76:179 (1961)

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4. Averette, H. E.: *et. al. Cancer,* 15:759 (1962)

5. Fischer, H. W., and Zimmerman, G. R.: *American Journal of Roentgenol,* 81:517 (1959)

6. Fischer, H. W.: *Radiology,* 79:297 (1962)

7. Zeidman, I., Copeland, B. E., and Warren, S.: *Cancer,* 8:123 (1955)

1010 Park Avenue

Doctors' Family in Need?

It is requested that any physician who is aware of a physician's widow or children who may be in financial need, and whose husband may have been a member of the Society for the Relief of the Widows and Orphans of Medical Men of New Jersey, communicate with the Society at P.O. Box 95, Belleville, N.J., 07109.

An otologist and an audiologist here offer a rapid and feasible program for detecting hearing defects in children.

Screening Of Hearing In School Children

Aris M. Sophocles, M.D.
Robert A. Muzzarelli / **Trenton**

The need for school screening is well demonstrated in a study at The Mercer Hospital Speech and Hearing Center of Trenton. We examined students from two school systems. In the one system (Area A), there has been screening done annually for many years. In the second system (Area B), screening was rarely done. In most of the Area B schools, children are tested only when suspected of having a hearing loss. The childern referred to us for otologic and audiologic study have proved losses. It was the degree of loss which impressed us as well as the response to treatment exhibited by these children.

The Area A children were discovered earlier and had an average loss of about 30 decibels. A large proportion of these responded to treatment. Their hearing returned to normal in a short time. These were the children with the highest number of conductive-type of hearing loss and the lowest number of sensori-neural hearing loss.

In Area B, the average loss was 40 decibels, with many more cases of sensori-neural loss and fewer of conductive losses than those in Area A. The response to treatment was not as good. More of this group fell into the "permanently handicapped" category.

This study involved three hundred students averaging seven years of age. The greatest incidence of respiratory infection is in the very young who have not developed sufficient resistance to infection. The greatest cause of the hearing problems was infection of the middle ear following colds, sinus infections, chronic tonsillitis, and allergies. Children discovered in the first six months of hearing loss were usually found to have serous otitis, while those of longer duration often had adhesive otitis. The latter frequently had various degrees of sensori-neural loss. Thus we find in this group those not responding to treatment. Among children not responding to medical or surgical treatment, we also found the largest number with learning problems and speech defects. Here, too, was the largest group of those requiring hearing aids and extensive rehabilitation. With this experience and after review of literature* on the subject of screening, we recommend the following to our school systems.

*Suggested Readings

Barr, B.: *Acta Oto-Laryngologica,* 1955, Supp. 121.
Curry, E. Thayer: *Journal of Speech and Hearing Disorders,* 15:211 (1950)

Davis, Hallowell and Silverman, S. Richard: *Hearing and Deafness.* New York: Holt, Rinehart and Winston, 1962. Chapters 4, 5, 6, 7, 17 and 20.

Landis, James E.: *Tr. Am. Acad. Ophth.* 56:73 (1952) "Services for Children with Impaired Hearing;" American Public Health Assoc., Inc., 1790 Broadway, New York 10019.

Streng, Alice *et al.*: *Hearing Therapy for Children,* Ed. 2. New York: Grune & Stratton, 1958. Chapters 2, 3, 6 and 7.

Wishik, Samuel M. and Kramin, Elizabeth R.: *Journal of Speech and Hearing Disorders,* Dec. 1953.

Wood, William L., M.D.: *Journal of The Medical Society of New Jersey* 61:222 (February 1964).

Frequency of Testing

1. Every child should be tested by "sweep check" once every year.

2. If necessary to compromise, every child from kindergarten to fifth grade should be checked yearly; then every other year up to the twelfth grade.

3. Children who failed tests in previous years must be followed annually.

4. Teacher referrals should be encouraged on suspected hearing problems for those who had not been screened during the school year.

Technic

1. **Screening:** An audiometer which has been either calibrated or tested annually by checking against hearing of ten known "normal ears" is used.

Test each child individually in a small, quiet room, not in a "group test" situation. With this technic, the examiner will develop further insight into a child's hearing and ability to understand instructions. Here, one usually observes unusual and persistent delays in response to the test tone. Because many children are apprehensive for their first hearing test, it is suggested that they be instructed in groups of six. The time initially spent in the instructions will alleviate any fears, and will save considerable time once the testing has been initiated.

The children are instructed to raise their hand the moment they hear a "beeping" sound and to put their hand down when they no longer hear it. The tone should be pulsed on and off to assist the child further in distinguishing the tone being presented from environmental noises. The interrupter on the audiometer should be set so that a tone is presented when the examiner depresses the switch.

By setting the intensity level of the audiometer at 15 decibels, the various frequencies are then checked rapidly. This completes the "sweep" or "screening test." It separates "normal hearing" students from those with need for further checking. Total time for this test should not amount to more than three minutes per child. The concept is to simply eliminate "normal hearing" children from those with "possible hearing loss."

2. **Threshold:** The threshold test is next done on the children who have not passed the original screening test. The concept here is to plot the intensity level for each frequency that the child is able to hear approximately 50 per cent of the time. The resultant "plot of threshold" is called the audiogram.

The test is initiated by turning the machine on with the frequency dial set at 1000 cps (cycles per second) and the intensity level at 35 db (decibels). If the child raises his hand to the stimulus, turn the tone off and *decrease* the intensity by 10 db. If the subject continues to hear, repeat this procedure by decreasing the intensity in 10 db steps until the child no longer responds to the tone. Then, *increase* by 5 db steps until he again hears the tone. This represents the screening threshold for that particular tone. Repeat this procedure by testing tones 2000, 4000, 8000 cps, and then returning to 1000 cps and proceeding down through 500 and 250 cps. (The retest at 1000 cps is done to test the reliability of the student's response.)

Shorter methods have been devised (such as screening only at the frequencies of 500, 2000, and 4000 cps) but the fewer the frequencies used, the greater chance for errors. The screening and threshold technics described above will not only assure you of detecting the hearing impaired, but will prevent over-referrals.

Referral Procedures

A loss of 20 decibels or more at any two frequencies in either ear or 30 decibels or more in any single frequency in either ear is medically significant. This child then "fails the school hearing screening test." The family is notified by a copy of the report.

These children should then be referred through the family physician to an otologist for a complete otologic and audiometric examination. The physician is then asked to complete the report to parents and return said report to the school (either through the parents or directly by mail). Should a report not be received by the nurse within six weeks, the parents should then be called to determine if they have followed through with the notification.

Summary

1. Screening or "sweep testing" of hearing: A fixed (usually 15 decibel) intensity, sweeping through all frequencies to separate normal hearing children from those with possible hearing disorders.

2. Threshold testing: A pure tone test of all frequencies to determine the exact hearing levels in children failing the sweep test.

3. Referral for otologic examination may be done before the threshold testing, but this lends itself to the possibility of many unnecessary referrals. It is better for someone in the school system to check the screening failures by threshold testing methods.

4. Children hard to test because of inconsistent or unreliable responses, or because of learning inabilities, can be referred to the audiologists in speech and hearing centers in the area. In this way, specific and diagnostic

audiometric studies can be made available to the physician.

5. A loss of 20 decibels or more at any two frequencies in either ear, or 30 decibels or more at any single frequency in either ear, is a basis for referral.

6. Our school systems will discover that about five percent of children are in some degree of difficulty with their hearing. Many of the behavior and "learning problems" can be avoided or alleviated. Diligent annual screening can discover those potential problems as well as those already experiencing difficulties.

7. Restored normal hearing can be achieved only if detection is carried out while we have this young "captive" population in school. Once they have left school, they retrogress; rehabilitation is then difficult, and fewer have hope of normal hearing again.

8. The total number of people in our country with abnormal hearing is estimated to be about ten percent of our population.

571 Bellevue Avenue

Association For Brain-Injured Children

Doctors who know of brain-damaged children will be conferring a favor on their families by acquainting them with the existence of the New Jersey Association for Brain Injured Children. This Association has 3 aims:

1. To encourage, develop, and establish educational, medical, and recreational programs for brain injured children.

2. To assist families of brain injured children with the numerous psychological, social, and familial problems resulting therefrom.

3. To aid and establish research programs in the field of perception and brain injury.

During 1965, the New Jersey Association's activities included:

1. The second year at Camp Laurel had an enrollment of 66 children. It was held five days a week for six weeks at Thompson Park in Jamesburg, New Jersey. Camp Laurel 1965 emphasized living in small groups, and reports of satisfaction with this camp experience from the campers, their parents, and the camp staff have been rewarding to all.

2. A special recreational program was held each Friday at the Highland Park Jewish Community Center. There is a parent counseling program held at the same time to discuss problems concerning the brain injured child. At the present time there is a waiting list for participation.

3. A swimming program is held each Tuesday at the Jewish Community Center.

4. This is the second year for a scout program. Four of the girls meet each Saturday morning with a senior girl scout troop. The girls are divided into brownies and junior scouts according to age and follow through on the regular scout program. Each senior scout is responsible for one child.

5. General meetings are held bimonthly with speakers from all fields of knowledge on the brain injured child. Notices of these meetings and other news items are mailed to members.

This is a new organization which needs support. Dues are $5 per family. Application blanks for membership are obtained from Mrs. F. Seelenbinder at 46 Sharon Avenue, Edison, N.J. 08818. Or, you can write to the committeeman nearest your address for more details. Here is the list:

Mr. & Mrs. R. Canning, 14 Appleman Road, Somerset, 201-247-1867

Mr. & Mrs. A. Cohen, 465 Gorham Avenue, Woodbridge, 201-634-4432

Mr. & Mrs. B. McMahon, 2991 Princeton Pike, Trenton, 609-882-0622

Mr. & Mrs. V. Sapienza, 437 Colonia Blvd., Colonia, 201-388-6253

Mr. & Mrs. J. Schepise, 1354 Joseph St., North Brunswick, 201-246-2066.

A liquid senna preparation is now available to eliminate gas and fecal matter from the bowel preliminary to x-ray examination. Good visualization was obtained in 93 per cent of the subjects.

An Effective Single-Dose Bowel Evacuant

Arthur J. Statman, M.D./Irvington

The value of roentgenography, a primary diagnostic weapon for the gastroenterologist, obviously depends upon the accuracy with which films may be read. This, in turn, is determined at least in part by the effectiveness with which fecal matter and gas are eliminated from the bowel prior to x-ray procedures.

For the past several years,* I have been using a palatable powder consisting of standardized senna concentrate — a preparation derived from the senna pod — for bowel clearance preceding roentgenography of the gastrointestinal tract. This has had several advantages over the widely used castor oil and enema, in addition to providing better visualization. It is more palatable, reduces the incidence of gastrointestinal disturbance, and eases administration since only a single oral dose is generally sufficient. These are advantages under any conditions, but are especially significant in office practice where patient cooperation in administering the medication properly at home is essential.

To enhance facility of administration still further, a liquid form of the standardized extract of senna fruit† has recently been prepared, also palatably flavored. This eliminates the need for aqueous mixing and dissolving the powder, thereby avoiding lumps and giving greater assurance that the entire measured dose will be ingested. It also simplifies measurement of reduced doses where required for children, and permits saving of the unused portion.

To determine whether this new liquid form retains or improves upon the efficacy of the powder, as well as to fix the optimal dose, a study was undertaken employing two measured doses — one of two ounces (containing the equivalent of 2.8 Grams of standardized extract of senna fruit) and one of 2½ ounces, containing the equivalent of 3.5 Grams of standardized extract of senna fruit, approximately equivalent to the amount of standardized senna concentrate contained in a prepared single dose of the powdered form.

The study involved 200 patients, ranging in age from 11 to 78 years. An initial group of 105 patients was treated with a prepared 2-ounce dose of the test agent, followed by a second group of 95 patients treated with a prepared 2½ ounce dose. In each group, however, children under 14 were given doses reduced by ½ ounce from the prepared doses. There were two such patients in each group. Average age of both groups was slightly more than 47 years. There were 16 patients in the first group and 15 in the second group, over 65 years. Fifty-one patients in the first group of 105 were female, as against only 38 in the second group of 95 patients.

Diagnoses were as follows:

* Statman, A. J.: American Journal of Gastroenterology, 33:740 (June 1960)

† X-Prep Liquid, supplied by the Medical Department, Gray Pharmaceutical Co., Yonkers, N.Y.



FIGURE 1. Dose of X-Prep Liquid — 2 oz. Some fecal retention in ascending colon.



FIGURE 2. Dose of X-Prep Liquid — 2 oz. Some fecal retention in ascending colon.



FIGURE 3. Dose of X-Prep Liquid — 2½ oz. No fecal retention noted.



FIGURE 4. Dose of X-Prep Liquid — 2½ oz. No fecal retention noted.

Diagnosis	No. of Pts. 2½ oz. dose	No. of Pts. 2 oz. dose
Irritable colon	21	29
Diverticulosis and/or diverticulitis	13	15
Functional or atonic constipation	10	14
Spastic constipation	2	3
Polyps — rectal or sigmoid	8	7
Postoperative adhesions	5	4
Duodenal or peptic ulcers	5	3
Splenic flexure syndrome	4	3
Ulcerative colitis	3	3
Carcinoma — colon	3	4
Endometriosis	3	2
Cholelithiasis and/or cholecystitis	2	5
Megacolon	2	2

There were scattered cases in both groups of postoperative colostomy, proctitis, ileitis, ovarian cysts, cirrhosis of the liver, hepatitis, amebic dysentery, and normal colons in severely neurotic patients.

All patients in both groups were prepared for barium enema procedures. Four patients in the first group and six in the second group were also prepared for a gastro-intestinal series; and two in each group were prepared, additionally, for gallbladder examination.

All patients were instructed to take the prepared doses between 2 and 3 p.m. on the day before the x-ray procedure. If they were present in the office or clinic at that time, the medication was administered to them. If not, they were instructed to administer it themselves. In all cases, they were also instructed to fill the bottle with water following ingestion of the medication and drink this as well. This assured ingestion of the entire dose. In the case of children, the appropriate dose was measured and the medication either administered at the office or given to parents with the appropriate instructions.

All patients were told to have a light, bland, fat-free luncheon on the day before the procedure, to eat no solid foods after 3 p.m., and to eat an evening meal of clear soup, plain Jello without fruit, apple juice, and tea or coffee without milk. They were told to avoid all liquids as well as solid foods from 10 p.m. until after roentgenography, which was scheduled for the morning. They were advised that "urge cramps" of the bowels were to be expected as a result of the desired vigorous action of the medication.

Patients were requested to keep careful record of bowel movements, including time, frequency, size and nature of stool, as well as of any side reactions.

Results

With the larger (2½ ounce) dose there was excellent visualization in 94 out of the 95 cases, or 99 per cent. In one case of megacolon, some feces remained, but the films were diagnostic nonetheless. No enemas were required for any of the patients in this series.

With the smaller (2-ounce) dose there was excellent visualization in 93 out of the 105 subjects without resort to enemas (89 per cent). In one instance, because of an unusually large megacolon, an enema was given prior to x-ray procedure as a cautionary measure, and visualization was entirely satisfactory. In ten cases, visualization was fair without enemas, but some feces or gas was retained in the cecum and ascending colon. In one patient, there was poor visualization with the medication alone and the procedure had to be repeated following an enema.

Thus, for the entire series of 200 patients treated with the test bowel evacuant, the radiographic procedure had to be repeated in only one instance; and in only two cases — including the initial failure — were enemas employed. Of the 198 patients who did not receive enemas, visualization was excellent in 187 (93.5 per cent of the entire series) and fair in the other eleven.

Evacuation time (from ingestion of the preparation to the initial bowel movement) ranged from 5 to 7 hours in 175 of the 200 patients. In 20 patients, it ranged from 2½ to 4½ hours; and in 5 patients (all of whom had received the 2-ounce dose) it was 7½ to 8 hours. Evacuation was more rapid with the 2½ ounce dose than with the 2-ounce dose — 5½ hours as against slightly over 6 hours. Of the 95 patients receiving the larger dose, 89 reported that stool evacuations were either normal or somewhat larger in size. Of the 105 patients receiving the smaller dose, 75 re-

ported that stool evacuations were either normal in size or larger. Stools were soft in most of the patients in both groups; hard in 6 of the patients getting the smaller dose and in only one receiving the larger dose. Approximately one-third of the patients in both groups had from one to three subsequent bowel movements prior to x-ray procedure.

Side Effects

Of the entire series of 200 patients, nine reported moderate griping; and seven, mild griping.

Among patients receiving the 2½ ounce dose, there were four reports of mild griping, an incidence of four per cent. No other side effects were reported in this group.

Among patients receiving the 2-ounce dose, nine reported mild griping and three reported moderate griping, or an incidence of 11 per cent. This larger incidence of griping with the smaller dose is probably a matter of chance, since the difference was not statistically significant.

Two patients — both in the smaller dose group — complained of transitory pruritus, which subsided spontaneously. Both were patients with a variety of allergies, and it was not determined whether their reactions were due to the medication.

Comment

Overall results of this study — excellent visualization in 93.5 per cent of the entire series — suggest that the liquid form of standardized extract of senna fruit is at least as effective as the powdered standardized senna concentrate, and is accompanied by a slightly lower incidence of griping. In a clinical study of the powder,* visualization was also excellent in 93 per cent, but the incidence of griping was 19 per cent as against 8 per cent in the current series.

The study indicated that the 2½ ounce dose was most effective, yielding more consistent visualization results and more rapid evacuation, with no greater risk of griping or other side effects than the lower dose under test. Patient acceptance of the medication was uniformly excellent, and the liquid form obviated the need for any preparatory mixing procedures.

The diet regimen which patients were instructed to follow for the 24 hours preceding radiography probably contributed to the high rate of excellent films. The relatively low incidence of griping complaints can probably also be accounted for by prior warning to the patient to expect "urge cramps" as an inevitable accompaniment of the purging process. While this is generally expected with castor oil, the mild, pleasant taste of the test agent may leave the patient unprepared for the vigorous purging action unless he is forwarned.

Summary and Conclusions

A liquid form of standardized extract of senna fruit (X-Prep Liquid)† was tested for efficacy in bowel cleansing preparatory to radiography of the gastrointestinal tract. Excellent visualization was obtained with a single oral dose and without resort to enema in 93.5 per cent of the 200 patients involved in the study, and fair visualization in another 6 per cent. In one patient, the medication did not result in a satisfactory film, and the procedure had to be repeated following enema administration. There was mild-to-moderate griping in 8 per cent of the patients. Two cases of pruritus were encountered, probably allergic in nature. Whether these were associated with the medication was not determined. Of two prepared doses tested, the larger (a 2½ ounce dose) proved more effective, with no indication of increase in side effects.

The medication was palatable, well accepted and easily administered in the office or at home by the patient. Proper preparation of the patient prior to radiography is stressed.

50 Ball Street

STATE ACTIVITIES

Trustees' Minutes

January 16, 1966

A regular meeting of the Board of Trustees was held on Sunday, January 16, 1966, at the Executive Offices. For the fuller information of the members, detailed minutes are on file with the secretary of your county society. A summary of the significant actions follows:

Health Facilities Council . . . Voted to contribute $5,000 in 1966 to the Health Facilities Planning Council of New Jersey, in accord with the action of the 1965 House of Delegates, which resolved "that The Medical Society of New Jersey affirm its continued official support and membership in the Health Facilities Planning Council for New Jersey."

Noted that Dr. John Kustrup of Trenton has been appointed as MSNJ representative on the council for a 3-year term (beginning January 1, 1966), succeeding Dr. Louis Wegryn of Elizabeth, who declined reappointment.

P.L. 89-239 . . . At the request of the Commissioner of Health, named President-Elect Joseph R. Jehl, M.D. officially to represent MSNJ during the first year of incorporation of the New Jersey Joint Committee for Implementation of P.L. 89-239 (Heart Disease, Cancer, and Stroke).

Generic Drugs . . . Approved the following opinion of Legal Counsel and directed that the information be sent to New Jersey hospital administrators, chiefs of staff, and chairmen of hospital pharmacy committees, for their attention:

With regard to the recommendation of MSNJ's Council on Medical Services concerning drugs by generic name and drug substitutes, I have inquired into the matter carefully by examination of the law and by conference with the Secretary of the State Board of Medical Examiners and the Deputy Attorney General for that Board.

It does appear to me that any action by hospitals requiring staff physicians to grant to hospital pharmacists the right to substitute similar drugs when a prescribed drug is not available is improper, if not illegal. In accordance with the statutes, no change can be made in a prescription "without the prescriber's permission having been obtained." I do not believe that a strict interpretation of the statute would allow for that permission to be given in advance for all subsequent prescriptions on the basis that to do so would be an improper delegation of the physicians' responsibilities. The Deputy Attorney General apparently is in accord with this thinking.

I am in agreement with the stand which MSNJ has taken opposing legislation that would compel physicians to prescribe by generic name only, and likewise I am in accord with the intention of the recommendation; however, I suggest a re-wording of the same in order to give greater emphasis to the necessity for the individual physician's consent to a change:

> That, through the appropriate agency, MSNJ call to the attention of the pharmacy committee in each hospital its responsibility to insure that no drug substitution will be made without the consent of the physician in charge *in each specific instance*, and further to assure prescribing physicians that the quality of any drug substitute suggested is satisfactory.

Medicare Program . . . Empowered the Executive Director to issue a reminder to member-physicians emphasizing that those who have contact with senior citizens urge these people immediately to enroll in Plan B.

Home Care Institute . . . Appointed Dr. Matthew E. Boylan of Jersey City as the Society's representative to the 9th Institute on Coordinated Home Care — the Impact of Medicare — to be held this month in New York.

Utilization Committees . . . Approved the recommendation of MSNJ's Council on Medical Services that requests be made to the Health Department for a list of extended care facilities in New Jersey which will utilize the services of review committees; that this list be distributed among the appropriate component societies; and that follow up be made to insure that review committees have been established, as requested.

Medicare Law . . . Approved the following recommendations of the Council on Medical Services — in view of the desire of the Health

Department to work as closely as possible with MSNJ in implementing the Medicare Law:

(1) The Commissioner of Health be informed that the Council on Medical Services has been designated by MSNJ as its "task force" for the Medicare Program in New Jersey.

(2) The services of the council be offered to the Commissioner of Health as available for any liaison purposes in implementing the program.

(3) In the area of Medicare concerns (P.L. 89-97), the President to consider for appointment the nominations of Dr. Eckstein as the official liaison representative from MSNJ to the Department of Health and Dr. Benz as the official representative to the Department of Institutions and Agencies for this program.

(4) Request be made to the Commissioner of Health and to the Commissioner of Institutions and Agencies for a copy of the plans that they respectively evolve for the implementation of Title XVIII and Title XIX of Public Law 89-97. Through use of such plans, the council will be in better position to act in the interest of the public and of the medical profession of New Jersey.

Specialty Groups . . . Approved the following report and recommendations of the Council on Medical Services:

The council was requested to meet with representatives of the specialties of radiology, pathology, anesthesiology and physiatry, "to help them evolve their position and to develop recommendations in preparation for the inauguration of the medicare program." Therefore, for this portion of the meeting, the representatives of the specialty groups — radiology, pathology, anesthesiology, and physiatry — were present.

Each of the specialty groups was given the opportunity of presenting its case before the council. General discussion followed, out of which came these conclusions:

(1) MSNJ supports — and has for a number of years — the position that the practice of pathology, radiology, anesthesiology, and physical medicine are branches of the practice of medicine, and the services of such specialties are professional and not hospital services.

(2) MSNJ supports the position that since the professional services rendered by physicians in hospital-based specialties are not hospital services, the fees for such professional services do not belong in any benefits paid for hospital services from any source.

(3) MSNJ supports that section of the Medicare Law which provides that fees for services rendered by hospital-based specialties shall be compensated under Part B of Title XVIII.

(4) MSNJ supports the hospital-based specialties in their determination to conduct their practice in such a manner and under such arrangements as will enable them to bill and receive compensation directly for professional services rendered.

(5) MSNJ supports the recent policy declarations of state and national hospital-based specialties, but recognizes that individual members are still at liberty to make whatever arrangements they wish with hospitals.

In support of the foregoing declarations, the council called attention to policy decisions taken by MSNJ as early as 1947, recognizing hospital-based specialties as branches of the practice of medicine and urging them to conduct their practices in the same manner and under the same terms as do all other practitioners.

The council further pointed out that many of the requests made by the specialty societies to MSNJ were already dealt with and provided for in the "Guides for Physician-Hospital Relationships," adopted by the 1964 House of Delegates.

The council said that specialty societies over the years had failed to take advantage of MSNJ's advice and assistance. Thus, the council was gratified that the specialty societies were now taking measures on their own to bring their practices in line with those suggested over the years by MSNJ.

The council concluded this portion of its meeting by requesting that:

(1) The specialty representatives report on today's meeting to their parent organizations.

(2) Each specialty society send to MSNJ an official statement of its policy declarations, including any formal requests or recommendations it desires to make to MSNJ.

(3) Those specialty societies having a relative value index or a professional component index send 10 copies to MSNJ for the files of the council and use of its Subcommittee on Compensation of Physicians.

(4) Specialty societies be encouraged to request the presence of representatives of the Council on Medical Services at meetings with the New Jersey Hospital Association and/or any other group discussing these matters.

Student Loan Fund . . . Approved the suggestion of the Medical Student Loan Fund Committee that pharmaceutical houses and others be invited to make commemorative contributions to the Medical Student Loan Fund in multiples of $100, in conjunction with the Society's Bicentennial Celebration; that the names of donors of $500 or more be inscribed on a plaque to reside permanently in the Executive Offices; and that the plaque read "Bicentennial Donor to the Medical Student Loan Fund of The Medical Society of New Jersey" followed by the donors' names.

Academy of Medicine . . . Reviewed at length with Dr. Sherman Garrison, MSNJ's representative on the Academy of Medicine Postgraduate Study Committee, the background of the proposed study as follows:

The initial aim of the committee was to be fact-finding and to promote information when and where it is required. Only by authorization of the Board of Trustees could the Society be committed to any program. At the October 1965 meeting of the committee (which Dr. Garrison was unable to attend) it was unanimously determined that Dr. Cross be retained as project director for the study, that he make necessary revisions in the original proposal, and that he then apply for funds to conduct the study. At this meeting Dr. Cross outlined his proposals. On receipt of the outline, Dr. Garrison wrote to Dr. Parsonnet explaining his view of the proposals. At its November 1965 meeting the committee unanimously voted to ask Rutgers Medical School to act as the fiscal agent for the project, for purposes of efficiency and to acquire grant money — noting that the agreement will be contingent upon the joint committee's retaining control of the study and responsibility for it and the results being published in the name of the sponsors of the committee. At this same meeting, in discussing possible methods of conducting this study, Dr. Parsonnet pointed out the importance of keeping in mind three questions: (1) What does the practitioner want in the way of continuing education? (2) How would he like it to be given? and (3) Why doesn't he take advantage of what is offered? The Academy of Medicine has withdrawn from active conduct of the project, which is now under the direction of an *ad hoc* committee of representatives from each of the originally sponsoring organizations: Academy of Medicine of New Jersey, State Department of Health, Rutgers Medical School, New Jersey College of Medicine, New Jersey College of Dentistry, New Jersey State Dental Society, and The Medical Society of New Jersey.

Following lengthy discussion, in which the Board expressed its dissatisfaction that the committee had acted without the sanction of the sponsoring agencies, it took the following actions:

(1) Requested Dr. Garrison to send to the Board of Trustees a copy of the minutes of each meeting of the study committee.

(2) Requested Dr. Garrison to inform the Board of Trustees when a significant matter comes before the committee, to enable the Board to know what is transpiring and to take appropriate action, if necessary.

(3) Voted to continue Dr. Garrison as MSNJ's official representative on the study committee.

(4) Approved a study of the 3 questions listed by Dr. Parsonnet and requested that the project be limited to these 3 items.

(5) Directed that a letter be sent to Dr. Parsonnet, with copies to all agencies represented on the study committee, declaring the Society's position with regard to the study and requesting their opinions.

Anti-Poverty Program . . . Discussed with the Commissioner of Health and his associate, Dr. James Pappas, the New Jersey Project for Medical Care for Disadvantaged Youth:

The beneficiaries under the project would include enrollees in the Neighborhood Youth Corps, participants in the Basic Adult Education programs, medical rejectees of Selective Service, and school drop-outs. The project would provide for medical and dental examinations and for the care of remedial defects. Both the examination and the care would be provided through agreements with selected hospitals. Enrollees whose defects are covered by existing programs would be referred to the proper agency — including the Crippled Children Program of the Department of Health, the Rehabilitation Commission, and the Commission for the Blind. A contract has been negotiated with Hospital Service Plan of New Jersey to serve as the bookkeeper, paymaster, and statistical facility for the services provided by the hospitals. The hospitals selected are located near the approved Neighborhood Youth Corps projects in New Jersey. Contacts are first made with physicians on the hospital staff to obtain their cooperation. Then, contact is made with the hospital administrator. In answer to a question as to whether MSNJ as a statewide organization should not have been first approached for approval of this statewide program rather than seeking the cooperation of the individual hospital staff, Dr. Pappas replied that the basic procedure has been the same for each of the twelve examining centers. The Trenton Center project was endorsed by the Mercer County Medical Society. Further, time was short in that the program will run only to July 1, 1966.

Concluded with Doctor Kandle and Doctor Pappas that it probably would not have been practical, because of the time factor, to clear the project through MSNJ before getting in touch with the hospital staff physicians.

MSP Board . . . Approved the following nominations submitted by Medical-Surgical Plan, to fill the vacancies in unexpired terms ending at the 1968 Annual Meeting which resulted from the resignation of Irving P. Borsher, M.D. and the death of Charles W. Barkhorn, M.D.:

Mr. Theron L. March — Executive Vice President and Cashier — National Newark and Essex Bank

Edwin H. Albano, M.D. — Pathologist

AMA Dues Increase . . . Referred to the New Jersey Delegates to the AMA a resolution from the Hudson County Medical Society disapproving the proposed AMA dues increase.

New Jersey College of Medicine . . . Directed that the following information be called to the attention of the Governor, the Board of Trustees of the New Jersey College of Medicine, and — if deemed advisable — to the general public:

The New Jersey College of Medicine will move out of the Jersey City Medical Center in February 1966. At present, third and fourth year students are commuting to many communities in New Jersey and New York for clinical training. The following was emphasized: (1) Clinical facilities should be quartered in one hospital so that students will not have to travel to so many areas; (2) The College Board of Trustees, in looking for medical consultants, should not go so far afield as they have since there are people within New Jersey and within The Medical Society of New Jersey well qualified to serve; and (3) Setting up clinical facilities for students is more important than setting up a private hospital where professors can conduct private practice.

Factors Affecting Professional Liability

Any physician involved, even remotely, within the framework of a professional liability suit may find that his actions and statements are used as a basis of premeditated litigation following his role in court. So, at its January 11, 1966 meeting, the Essex County Medical Society held a colloquium to introduce its members to "Current Factors Affecting Professional Liability."

Major safeguards recommended by the panelists, who included Jerome G. Kaufman, M.D., past-president of The Medical Society of New Jersey, are:

Early reporting to your carrier of any situation which might result in a malpractice suit. This gives the professional liability carrier vitally needed time to investigate and establish a defense on behalf of the physician.

Do not discuss any patients with non-representative attorneys; do not offer medical advice regarding patients, especially if you have never professionally seen or treated them. There are lawyers who telephone unsuspecting doctors about a person's physical condition. But, simultaneously, the conversation is transcribed without the physician's knowledge. This transcript can later be used in establishing a case when submitted for inclusion in court records.

When an attorney communicates with you for any doubtful reasons, inform him you will have *your* legal representative return the call. Let your carrier or legal representative talk for you. They are fully aware of the repercussions of such a conversation.

Chart and maintain accurate records. If the patient is a competent adult, keep the records for at least ten years. If the patient is under the age of 21, hold the records intact until he becomes 23 years old. This is because the "statute of limitations" in New Jersey runs for two years. And for children and incompetents, it doesn't start running until the incompetent regains his competency, or until the child reaches the age of 21. For contracts, the statute of limitations here is six years.

If you have to make a scratch-out or deletion, do so; but make a notation elsewhere giving the date of and reason for the correction.

Prepare records immediately after seeing the patient. Juries believe written records sooner than unrecorded recollection. They believe records made right at the time over records prepared days or weeks later.

Check mail received from attorneys yourself. Do this when you receive it. If unusual in content, or, possibly, a court document, call your carrier or attorney. It could be an order for a deposition or interrogatory, which is the nearest thing to giving testimony outside the courts. Your statements are taken under oath by a court-reporter. These statements can be used against you in the future. Call your lawyer or the insurance carrier before giving a deposition. This also holds if you receive a complaint that suit has been filed against you; or if you are served with a summons to appear in court in a medical or medically related case.

With this increase of the role of the doctor in court, a new and foreign dimension outside the daily medical routine and activities is added to his profession which calls for self-protective measures and increased reliance on the physician's legal representatives.

For Medical Society members, the determination to "fight or compromise" a case is made by the county society's review board which then instructs the carrier of the decision.

Mr. Joseph A. Britton, general manager of the Professional Liability Division, American Mutual Insurance Company, said the primary function of his firm (after the decision is forwarded to them as a carrier) is to provide legal measures and protection for the doctor.

Because there must be immediate legal counteraction to any professional liability threat, he recommends that you get in touch with the carrier "as soon as possible; and if possible, before the problem even arises."

This allows full investigation of all circumstances, according to Mr. Britton, whose firm specializes in medical professional liability coverage. Then, with the determination of the local society review board, the company proceeds to establish a defense or effect a settlement. The necessity for the individual physician is to avoid the "pitfalls that cause claims," which Mr. Britton said is the purpose of panel discussions on malpractice presented at county level to keep doctors well-informed.

Doctors are cautioned that statements made within the legal framework are "something they will have to live with for years." The reason, said the carrier representative, is that statements "crystallize," and thus form an inflexible basis which the doctor will find difficult to counteract when appearing in court as the case is heard several years later.

The significance of testimony or statements, according to panelists, is that they are made within a general framework, while the court interpretations are based on specific fragments which relate only to the patient and the results to his physical condition and well-being.

An example of this type of "admission" is where a doctor verbally affirms responsibility for treatment merely to overcome a trying situation, even though he had no responsibility in the case. In such instances, the physician is urged to have a colleague on hand as a witness to corroborate his statements. This protective measure also holds in obtaining "informed consent," whether from the patient, his guardian, or his relative. Your witness can be your protection that you did explain possible hazards, results, and experimental life-saving procedures.

Because of these possibilities, the panel concluded that every doctor should carry professional liability coverage of at least $200,000; but more realistically, $500,000 to 1½ million, or in any case, at least what the individual doctor can afford.

Court decisions will be made years after the complaint has been filed. The extent and nature of awards for malpractice can change drastically during the interim. This is what the physician must be prepared for if he is involved in a professional liability suit.

Panelists on "Current Factors Affecting Professional Liability" were: Marcus H. Greifinger, M.D., moderator; Jerome G. Kaufman, M.D., past-president of The Medical Society of New Jersey; Ernest Hillman, Jr., M.D., chairman, Essex County Insurance Committee; William P. Braun, Esquire, legal representative for the Essex County Medical Society; Frederick B. Lacey, professional liability defense attorney for Shanley & Fisher; and Joseph A. Britton, general manager, American Mutual Insurance Company professional liability division.

New Post for Dr. Maurer

Dr. William R. Maurer, Jr., of our Bergen County Medical Society, has just been promoted to the post of Associate Medical Director at J. B. Roerig. Dr. Maurer, who has his M.D. from Cornell, had been associate director of surgery at Pascack Valley Hospital. He is a diplomate of the American Board of Thoracic Surgery.

Welcoming The Utilization Review

At the request of Dr. David Eckstein, chairman of our Subcommittee on Utilization (to the Council on Medical Services) — and with the permission of the message's author, Dr. Robert E. Fullilove, Jr. — we here reprint a slightly abbreviated version of an item from the January 1966 *Bulletin* of the Essex County Medical Society. The author (Robert E. Fullilove, Jr., M.D.) is president of the Essex County Medical Society. His message is reprinted below with permission of the staff of that Society's *Bulletin*.

Utilization Review Mechanism Necessary Under Medicare

On November 27, 1965 the AMA held an all day seminar on Utilization Review at the Philadelphia Convention. It is significant as an indication of the great importance of this subject that the response was tremendous. A program originally set up to handle an audience of six hundred expanded to such dimensions that other rooms had to be pressed into use and a closed circuit TV had to be utilized in order to handle the crowds of physicians who registered for it.

Before attempting to present a digest of the excellent material which they brought back, it might be well to state bluntly and clearly the inescapable fact that The Good Old Days Are Gone Forever. Meaning, of course, the good days of freedom from federal supervision, the days when the physician was relatively free to treat his patients with only his conscience and concern for his reputation in the community as guides, and without having his motives and methods examined by tissue committees, utilization committees, and judicial committees. Before we go into deep mourning over the passing of these good old days, however, we should consider the fact that they have been gone for some time. They started to leave when it first became impossible to practice medicine by simply hanging up a "shingle" and stating that one had "read" medicine and learned its arts and practices by preceptorship at the hands of an older physician. They receded further with the regulation of medical schools and hospitals, and still further with the rise of state boards and the growth of specialty boards, all concerned with standards of quality with respect to medical care. In short, what we are facing now is essentially an extension of these mechanisms of quality control. To suggest that American Medicine is opposed to the expansion of these control mechanisms is to suggest that American Medicine has something to hide, and has been guilty of short-changing the public. This is certainly not the case.

The law requires that any institution electing to participate in the Medicare Program must have a utilization review plan. The mechanism of review could consist of a committee including two or more physicians, or a group outside the hospital which is similar in composition to the staff committee. The medical profession have been thinking along these lines for quite some time.

The staff committee or other mechanism would be responsible for two kinds of reviews. The first would look into the elements of utilization — admissions services provided and lengths of stay — from the standpoint of their medical necessity. The second kind of review would be concerned mainly with length of stay. When the findings of the physician members of the committee (with respect to the medical necessity for continued hospitalization) disagree with those of the attending physician, the committee is required to notify the attending physician and to provide an opportunity for consultation between the committee and the physician. I consider this important, for it means that no outside person will have the power arbitrarily to decide on the date on which I should have discharged a patient, without giving me the opportunity to defend my medical judgment as vigorously as I can.

It is contemplated that each hospital will be asked to prepare a written description of its utilization review plan covering:

1. The organization and composition of the committee.

2. The frequency with which the committee meets.

3. The type of records it maintains.

4. The criteria used by the committee in selecting cases on a sample or other basis.

5. The committee's working definition of what constitutes a "period of extended duration."

6. The relationship of the utilization review plan to claims administration by a third party.

7. The responsibilities of the hospital's administrative staff in relation to the performance of utilization reviews.

It will be readily seen that all of this is quite similar to the AID programs already instituted by most hospitals in cooperation with Blue Cross and Blue Shield. The point to be emphasized is that, even though the federal government now gets into the act, we still have the opportunity to regulate and police our actions on the local level. If we abdicate our responsibilities, the alternative of further — and probably tighter — federal supervision is clearly provided by law.

Dr. Rogers' Book Now Available In Korean

Our historian, Dr. Fred B. Rogers, has authored a well-known *Syllabus of Medical History*. Announcement is now made that a Korean translation by Dr. Choi Jin Hwan has just been released. A Spanish translation is also now available. A paper-back edition of this work can be obtained from Little, Brown and Company of Boston.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—Neal H. Isil, M.D., R.R. #1, Box 161, Fort Madison, Iowa 52627. University of Istanbul (Turkey) 1955. Board Certified. Available immediately.

CLINICAL PRACTICE—George V. Clift, M.D., 217 William Street, Minoa, New York. Columbia University 1958. Board eligible. Internal Medicine—training endocrinology. Available July 1966.

GASTROENTEROLOGY/INTERNAL MEDICINE—Arnold Weiner, M.D., The Hahnemman Medical College and Hospital of Philadelphia, Department of Gastroenterlogy, 230 North Broad Street, Philadelphia, Pennsylvania. State University of New York 1961. Three years residency; fellow in Clinical Gastroenterology. Available July 1966.

GENERAL PRACTICE—Edward G. Krug, M.D., 142 Merson Drive, Buchanan, Michigan 49107. Wayne State University 1958. Available immediately.

Vincent R. Moloney, M.D., 301 Danube Avenue, Apt. #2, Davis Island, Tampa, Florida. Temple University 1965. Available July 1966.

Edmund J. Gaffney, M.D., Jeannette Apts. #312, 130 Long Lane, Upper Darby, Pennsylvania. University of Cincinnati 1960. Board eligible general surgery. Available July 1966.

Anthony J. DiCroce, M.D., 1218 Broad Street, Durham, North Carolina. Duke University 1965. Available July 1966.

GENERAL SURGERY—Joseph J. Voytek, M.D., 417 Mechanic Street, Fort Atkinson, Wisconsin. New York Medical College 1949. Board eligible. Available immediately.

GENERAL AND/OR VASCULAR SURGERY—Lester P. Eidelhoch, M.D., 240 Cherry Hill Drive, Bridgeport, Connecticut 06606. New York University College of Medicine 1956. Board Certified. Available immediately.

INTERNAL MEDICINE — Michael A. Bokat, M.D., The Clinical Unit of the Tufts-New England Medical Center, 171 Harrison Avenue, Boston, Massachusetts 02111. Albert Einstein College of Medicine 1961. Board qualified, internal medicine; training in endocrinology. Available immediately.

Francis X. McGinn, M.D., 6601 Broadway, Bronx, New York 10471. New York University School of Medicine 1961. Available immediately.

Alfred M. Derrow, M.D., 76A Bowdoin Street, Malden, Massachusetts. Tufts 1962. Available July 1966.

Harold J. Kobb, M.D., 6400 Pinefield Road, Columbia, South Carolina 29206. Jefferson Medical College 1960. Available July 1966.

Bernard J. Grimes, M.D., 126 North Linden Avenue, Pittsburgh, Pennsylvania 15208. University of Pennsylvania 1960. Available August 1966.

Martin B. Bauman, M.D., 10 Holmes Lane, Willingboro, New Jersey 08046. Chicago Medical School 1960. Three years residency. Available July 1966.

Theodore A. Kowitz, M.D., 19 Millstone Road, Randallstown, Maryland. University of Pennsylvania 1958. Board certified. Available immediately.

Bruce A. Talmadge, M.D., 1430 Spear Street, South Burlington, Vermont 05403. University of Virginia 1957. Board eligible. Special interest in cardiology. Available July 1966.

Jerome H. Siegel, M.D., 2441 Webb Avenue, Bronx, New York 10468. Medical College of Georgia 1960. Available July 1966.

Leroy Strom, M.D., 12403 Stretton Lane, Bowie, Maryland. Available July 1966.

James A. Robinson, M.D., 170 Castleman Road, Rochester, New York 14620. Columbia University 1961. Board qualified. Available July 1967.

INTERNAL MEDICINE/CARDIOLOGY—Thomas G. Higgins, M.D., Cardiology Branch, Medical Service, U.S. Naval Hospital, Portsmouth, Virginia. Georgetown University 1960. Board qualified. Available July 1966.

INTERNAL MEDICINE/HEMATOLOGY—David Prager, M.D., 600 Fulton Avenue, Hempstead, New York 11550. Chicago Medical School 1958. Diplomate, Internal Medicine. Available June 1966.

NEUROSURGERY—Mario Ludmer, M.D., 256 Highland Avenue, Pittsburgh, Pa. 15229. University of Buenos Aires School of Medicine 1956. Board eligible. Available immediately.

OBSTETRICS AND GYNECOLOGY—Birute S. Preikstas, M.D., 729 West Corrington Avenue, Peoria, Illinois 61604. Eberhard-Karls University, Tuebingen, Germany 1949. Specialty training in obstetrics and gynecology. Available immediately.

Irwin H. Roseman, M.D., 134 Sachem Road, North Kingstown, Rhode Island. University of New York (downstate) 1959. Completed Part I of American Board. Available July 1966.

Robert E. Lubanski, M.D., 124 Clifton Place, Syracuse, New York 13206. Upstate Medical Center, Syracuse, New York, 1962. Available July 1966.

OPHTHALMOLOGY—Vivian Chen, M.D., 3475 Greystone Avenue, Bronx, New York 10463. New York University School of Medicine 1962. Board eligible. Available June 1966.

ORTHOPAEDICS—Clarke Russ, M.D., 9239 Prevost Street, Detroit, Michigan 48228. Albany Medical College 1959. Military service completed 1962. Available July 1966.

PATHOLOGIST—James Ernst Haines, M.D., Worcester Foundation for Experimental Biology, 222 Maple Avenue, Shrewsbury, Massachusetts. Stanford University Medical School 1955. Board certified in Anatomical Pathology. Board eligible in Clinical Pathology. Available October 1966.

PEDIATRICS—Joseph A. Cannaliato, M.D., St. Lukes Hospital Center, 113 Street & Amsterdam Avenue, New York, New York 10025. Seton Hall College of Medicine 1963. Available July 1966.

Roger Kane, M.D., 7430 Pinedale Drive Columbia, South Carolina. University of New York (downstate) 1961. Board qualified. Available July 1966.

Donald L. Errante, M.D., 1837 Seminole Avenue, Bronx, New York 10461. University of Rochester School of Medicine 1960. Board qualified. Group practice—suburban area of northern New Jersey. Available July 1, 1966.

Gerald Lieberman, M.D., 1200 North State Street, Los Angeles, California 90033. Albert Einstein College of Medicine 1961. Associateship—solo—West Orange or New Brunswick area. Available July 1, 1966.

PEDIATRIC ALLERGY—Fredric A. Schulaner, M.D., St. Christopher's Hospital for Children, 2600 North Lawrence Street, Philadelphia, Pennsylvania 19133. Tufts 1959. Board certified (Pediatrics). Available September 1966.

PEDIATRIC AND GENERAL SURGERY—Richard W. Brenner, M.D., The Children's Memorial Hospital, 707 Fullerton Avenue, Chicago, Illinois 60614. Columbia 1958. Board certified—general surgery. Available fall of 1966.

SURGERY—David M. Hirsch, Jr., M.D., 2835 Webb Avenue, Bronx, New York 10468. University of Chicago 1959. Board eligible. Available January 1966.

Donald J. Shutello, M.D., 1853 Warhawk, Bunker Hill A.F.B., Peru, Indiana. Georgetown University 1962. Locum tenens general and limited surgery in Middlesex, Ocean or Union Counties. Available July, August, and September 1966.

SURGERY AND GENERAL PRACTICE—Ralph N. Lee, M.D., Veterans Administration Hospital, Fort Howard, Maryland. Howard University Medical School 1960. General surgical residency. Available immediately.

BICENTENNIAL CELEBRATION
May 14-16, 1966
Haddon Hall, Atlantic City

COMMUNITIES SEEKING PHYSICIANS

The following communities have written to the Executive Offices of MSNJ seeking information on possible physicians to fill vacancies. The information listed below has been supplied by the communities and verified by the counties. If you are interested in any further information concerning these communities, we suggest you make inquiries directly of them.

LONG VALLEY (WASHINGTON TOWNSHIP) — Morris County, population of 4500. General practitioner preferably; or obstetrician-gynecologist or pediatrician. One other general practitioner in community. Contact Mrs. David Bressler, Coleman Road, Long Valley, New Jersey; or phone 201-876-3757.

SEVERAL IN SALEM COUNTY, YOUNG GENERAL PRACTITIONERS—New Jersey Chapter of the American Academy of General Practice offers individual services to counsel and introduce to the communities interested physicians. Contact William L. Sprout, M.D., 69 Market Street, Salem, New Jersey

ULYSSES (POTTER COUNTY) PENNSYLVANIA — Population 600; surrounding area, 4,000. General practitioner needed. No other physician within 14 miles. Contact Merle Herr, Ulysses, Pennsylvania. Phone: 814-848-7572.

OBITUARY

Dr. Milton Manette

At the untimely age of 53, Dr. Milton Manette died of an acute coronary attack while attending a patient at the Christ Hospital in Jersey City. Born in Hoboken in 1912, he earned his M.D. at Hahnemann in 1938 and then returned to his native Hudson County to intern at the Christ Hospital there. He was active in the affairs of the North Hudson Physicians' Association as well as in the Hudson County Medical Society. Dr. Manette was a well-known Union City general practitioner.

BICENTENNALIA

'The Microcosm': A Centennial Epic (1866)

The Medical Society of New Jersey, celebrating its centennial on January 24, 1866 in the chapel of Rutgers College, heard Dr. Abraham Coles deliver his presidential address in verse. Titled *The Microcosm,* this epic discussed the human body in poetic fashion. Well known as an author, Dr. Coles read his long poem (47 printed pages) recalling the eighteenth century British physician-poet John Armstrong's words about Apollo, patron of the Medical Society and mythical god of healing, music and poetry:

> Music exalts each joy, allays each grief,
> Expels diseases, softens every pain;
> And hence the wise of ancient days adored
> One power of physic, melody, and song.

Abraham Coles, born at Scotch Plains, N.J., on Dec. 26, 1813, received a sound classical education before studying medicine. His doctoral thesis at Jefferson Medical College (from which he was graduated in 1835) had as its subject, "The Human Frame . . . as Exhibiting the Wisdom of the Deity." A devout student of the Bible, he linked medicine and religion and regarded his own profession as a sacred one. Settling in Newark, Dr. Coles became an eminent practitioner. Elected vice president of The Medical Society of New Jersey in 1860, he served in this capacity for five years before assuming the presidency. He was the 72nd presiding officer in a distinguished line.

The Microcosm, a "physiological poem" prefaced by Socrates' phrase, "Know Thyself," was patterned after the ancient Roman epic, *De rerum natura* (On the Nature of Things), by Lucretius. "I offer no apology for mixing up my Religion with my Science," Coles wrote in his preface. The stately passages and quaint flavor of *The Microcosm* have been compared to the poetry of George Herbert (on the devotional side) and the verse of Dr. Erasmus Darwin — grandfather of Charles — (on the naturalistic side). The sections of Coles' narrative entitled, *Charity, Physician, Opiferque per orbem dicor** and *Physician's Character and Aims — Science Progressive,* pertain to the practice of medicine and are worthy of quotation:

> O Ye devoted to the Healing Art
> By solemn consecration, set apart . . .
> Whose special function 'tis to give relief
> In the dark hour of suffering and of grief;
> Between the living and the dead, to stand
> Where fall the shafts of death on either hand;
> Without one thought of flight, to still maintain
> Perpetual battle with the Powers of Pain . . .

> "Knowledge is power," and here 'tis power to save,
> A power like God's to rescue from the grave.
> Each Year adds something — many things ye know
> Your sires knew not a Hundred Years ago;
> Art grown to more, your sons will higher climb,
> And make the Coming Centuries sublime . . .

Originally printed in the Society's *Transactions* for 1866, this work was later published in 1881 together with Coles' "National Lyrics" and "Miscellaneous Poems" as, "The Microcosm and Other Poems."

Abraham Coles is remembered today chiefly as a writer and translator of hymns. His eighteen different versions of the *Dies Irae* (Day of Wrath), a medieval chant describing the Judgment Day, astonished the contemporary literary world. His hymnal, "Old Gems in New Settings," and his translation of "The Psalms of David" displayed proficiency in dead and modern languages. Active on the Newark Board of Education, Dr. Coles was one of the founders of the Newark Public Library, the New Jersey Historical Society, and the South Baptist Church in Newark. He died of pneumonia on May 3, 1891. His son, Dr. J. Ackerman Coles (1843-1925), continued his father's medical practice. A monument honoring Dr. Abraham Coles stands in Washington Park, Newark, in appreciation of his many contributions to that city.

Fred B. Rogers, M.D.

* If you look closely on our Society's stationery or on the cover of this JOURNAL, you will see on our seal the Latin phrase: *Opiferque per orbem dicor.* As surely every doctor of medicine knows, this means: "And I am known throughout the world as the bearer of good things."

ANNOUNCEMENTS

Cardiac Symposium: March 30

General practitioners and cardiologists are reminded to set aside Wednesday afternoon, March 30 (2 to 5 p.m.), for an all-afternoon colloquium on the intensive care of the cardiac. The three speakers are Simon Dack, M.D. (director of the cardiac clinic at New York's Metropolitan Hospital); Dr. Samuel M. Fox, who is Deputy Chief of Heart Disease Control for the USPHS; and Dr. Thomas Killip, Assistant Professor of Medicine at Cornell. The seminar will be at the Robert Treat Hotel, Park Place, Newark. For more details, write to the New Jersey Heart Association at 235 Chestnut Street, Roselle, N.J. 07203.

Radiology in Ear, Nose, Throat

On Wednesday, April 6, at the Beth Israel Hospital, 203 Lyons Avenue, Newark, you can participate in a symposium on roentgenology and radiotherapy in ear, nose, and throat work. The program is offered twice — once from 9:00 a.m. to 12:30 noon; and it is repeated from 2:00 to 5:30 p.m. This program is under the aegis of the New Jersey Academy of Ophthalomology and Otolaryngology. For detailed program, write to Dr. Leon J. Schwartz, 162 Chestnut Street, Rutherford, New Jersey.

Audiology Day in South Jersey

A fact-filled program with a star-studded faculty is yours for the listening on Wednesday, April 27, at the Cherry Hill Inn in Cherry Hill, New Jersey. The morning program opens at 9:00 a.m. and luncheon is served at 12:30. The afternoon colloquium opens at 2:00 p.m. and ends at 5:30. Audiologic patterns, testing, and aids are on the morning schedule. The afternoon program includes a demonstration of the applied anatomy of the ear and temporal bone area, a discussion of middle ear surgery, and a paper on pitfalls in audiometry. For more details, write to Dr. L. J. Schwartz at 162 Chestnut Street, Rutherford, New Jersey. The New Jersey Academy of Ophthalomology and Otolaryngology has sponsored this meeting.

Community Psychiatry

On the first day of Spring, March 21, 1966, Dr. Milton Rosenbaum will speak on community psychiatry at 12:30 p.m. at the State Hospital, Marlboro, New Jersey. Dr. Rosenbaum is chairman of the psychiatry department at the Albert Einstein College of Medicine in New York. For more information, write to Dr. Michael Simon, State Hospital, Marlboro, New Jersey 07746.

Middle Ear Surgery

On your way back from our Annual Meeting in Atlantic City, stop in at Newark to take part in a symposium on middle ear surgery. Sponsored jointly by the New Jersey Academy of Ophthalmology and Otolaryngology and the Academy of Medicine, this colloquium brings you a star-studded faculty. For more details, write to Academy of Medicine, 317 Belleville Avenue, Bloomfield. The symposium is scheduled for Wednesday, May 18.

Heart Association Seminar in Newark

On Wednesday afternoon, March 30, the N.J. Heart Association will hold its annual scientific seminar at the Robert Treat Hotel in Newark. The theme of this year's colloquium is "Intensive Cardiac Care." The opener will be a talk on "The Avoidance of Death." The program also includes a discussion of newer instrumental technics and on medical treatment in heart disease. A star-studded faculty has been provided. For more details, write to the New Jersey Heart Association at 1500 Kings Highway, Cherry Hill, N.J.

LETTERS TO THE JOURNAL

Acute Leukemia vs. Benign Lymphosis ("Infectious Mononucleosis")

Dear Sir:

During the 40's, our research team reached the conclusions that acute leukemia was a *hematomyelosuppressive* disorder (an unpopular, though not an original, idea with us), that it was potentially remissible, and that the newly emerging "antimitotic" therapies were exactly the wrong modalities to apply (EENT Monthly, *26*, 84 February, 1947). Cogently enough, the premise of decelerated cell proliferation in the relapsant phase of this condition arose around a concomitantly diminished blood cholinesterase (*Science, 104*, 449, November, 1946), and it was suggested that such a laboratory test would assist in the differential diagnosis between acute leukemia and benign leucopathies (M. Rec., *162*: 16; January, 1949). But this was before blood cholinesterase determinations were as commonly available as they now are because of their usefulness in insecticide poisoning.

As a public health official I have been in contact with many scientists who evince queasiness over the statement that, while corrected death-rates in cancer have generally risen over the past two decades, there continues to be "agency-exhibition" of a marked rise in life-duration of the child with acute leukemia. Around the validity of this "exhibit" is being waged a furious rear-guard action in defense of the cytotoxic anti-cancer drugs already under heavy flank-pressure from both scientists and investigative bodies. If such drugs "work" in acute leukemia, then all is not lost. "All" in this instance could mean, to a research agency, a lot of grant-in-aid largesse. On the other hand, some in the field maintain the likelihood that the "prolonged survival" in the leukemia patients is based on faulty intelligence; that children with benign or Pfeiffer's lymphosis are more frequently being misdiagnosed as — and mistreated for — acute leukemia than was the case prior to the use of the antifolic and antimetabolite drugs. Diagnostic confusion between "AL" and "IM" has always been admitted and (rightfully) excused by even the most competent hematologist who knows the fallacy of the reliance on any modification of the heterophile antibody tests. Prior to antimetabolite therapy, the erring physician could feel embarrassment but no guilt. The story may be different today. The antimetabolite drugs are better tolerated by the subject with henign lymphosis, and hence (some say) the isolated instances of purported long survival of acute "leukemics." But who might have been all right in the long run had they the drugs are dangerous and can he fatal in patients chanced to miss out on the inevitable "blood-test."

But I recognize inevitability, and so I recommend that those forced into presumptive diagnosis read the exhaustive review on the utility of blood cholinesterase levels by J. C. Sabine in the *American Journal of Medicine*, July 1959. The test is now within the scope of every community hospital. If Sabine's tenets are correct, an occasional child might thereby be spared malignant treatment for what is really a benign condition. While awaiting the results of the test Mauer's report (Lancet, Sept. 26, 1964, page 675) could be perused prior to making for the anti-fol container. When its data is digested, one may waive speculation around disease definition in terms of prognosis and conclude that some inherently extant acute leukemics remained alive simply on the basis of remaining undiagnosed.

Robert D. Barnard, M.D.
95 Salem Road
Lakewood, New Jersey

WANT TO BE A BOOK REVIEWER?

Members sometimes ask what it takes to qualify as a book reviewer for this JOURNAL. The reviewer keeps the book. We need doctors who will send in the reviews within five weeks after getting the book. We can use not only specialists but also GP's, since many medical texts are aimed at family doctors. If interested, send in your name, address, kind of book you would like to review, plus assurance that you can have the typed review back within five weeks. Ask for our reviewers' instruction sheet. Write: Editorial Office, The Medical Society of New Jersey, P. O. Box 904, Trenton, New Jersey 08605.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

BICENTENNIAL CELEBRATION

Annual Meeting

Saturday-Wednesday

May 14-18, 1966

Haddon Hall, Atlantic City

PLAN TO ATTEND

BOOK REVIEWS

New Drugs 1965. Published in Chicago by the American Medical Association. Pp. 513. ($5.00)

Aimed at the practitioner, this new and concise volume answers the questions a doctor would normally ask about new drugs. This meets the need for *objective* evaluations of drugs, so that the physician does not have to depend on the sometimes self-interested appraisals by the company's service representatives. The text covers all useful drugs that have been introduced in the last ten years. The side-effects and contra-indications are clearly spelled out. A set of convenient tables at the end of the book makes this an even more useful volume.

ULYSSES S. FRANK, M.D.

Rypins' Medical Licensure Examinations. Edited by A. W. Wright, M.D. Ed. 10. Philadelphia, 1965, Lippincott. Pp. 840. (Price not stated).

The traditional question-and-answer method is here replaced by a compact summary of each field, with questions (but not answers) at the end of each section. The student thus has to sweat out the answer for himself, which is probably all to the good. The book—since it was first released in 1933—has been popular for thirty years and is now in its tenth edition. With such an accolade, praise for a review today would seem unnecessary. By its constant use and re-issue, it has been reviewed, in effect, by a generation of students, interns, and residents.

VICTOR HUBERMAN, M.D.

Pediatric Electrocardiography. By Warren G. Guntheroth, M.D. Philadelphia, 1965, W. B. Saunders Company. Pp. 150, illustrated. ($7.00)

This book on electrocardiography and vectorcardiography was written with emphasis on its application to pediatric practice. The general principles of electrocardiography are discussed, including such topics as scalar leads both unipolar and bipolar, as well as the vector lead systems.

The disorders of rate, mechanism, and rhythm are adequately detailed followed by a description, with excellent illustrations of the normal electrocardiogram at various age limits, beginning at birth to one month and extending to the last age group 12 to 16 years.

There is a long chapter on the various types of electrocardiograms found in hypertrophy, which is followed by a consideration of disorders of repolarization. The final chapter deals with methods of reporting electrocardiograms and contains a classification of congenital heart disease based on electrocardiographic, clinical and physiological status.

The book is well written and illustrated. It is highly recommended to pediatricians, general practitioners, and others interested in this subject.

JEROME G. KAUFMAN, M.D.

Atlas of Cataract Surgery. John M. McLean, M.D. St. Louis, 1965, Mosby. Pp. 130 with 80 Illustrations. ($20.00)

A detailed, well-illustrated step-by-step description here presents the methods of cataract surgery found to be most practical in the eyes of Dr. McLean. The information incorporated in his course in cataract surgery at the annual meeting of the American Academy of Ophthalmology is now compiled for the operating surgeon, including preoperative preparation and postoperative management. A concise text appears on the left page facing the superb large illustrations, adding to the continuity of the text.

The operating surgeon may not agree completely with all aspects in the technic surgery presented by Dr. McLean. Every surgeon, however, will benefit and perhaps modify his own procedure by one of the well presented variations in technic offered. The original illustrations are magnificent and orient the surgeon as he views the operation.

Perhaps the title of this text suggests an all-inclusive presentation of surgical approaches rather than the methods the author has found to be most practical. A more pertinent title would convey the purpose of presenting a course in cataract surgery in atlas form.

HOWARD M. EISENSTODT, M.D.

Neurologic Surgery of Trauma. Edited by Arnold M. Meirowsky, M.D. Washington, D. C., 1965, Government Printing Office, United States Army Medical Service. Pp. 604, with 273 illustrations. ($6.25)

Civil Defense authorities have estimated that, in another World War, they expect at least fifteen million injured who would need care and perhaps an equal number of dead. This text on the neurosurgical treatment of injuries to the brain and spinal cord is written with one purpose in mind—to synthesize the technics and results learned during the Second World War and Korean War. The editors point out that injured patients are to be evaluated swiftly in an effort to determine who could be returned to activity and who were expected to die. At the end of each chapter, there is a good correlation of anatomy, physiology, and practical application.

The most pertinent factor in the successful treatment of craniocerebral trauma is that morbidity from complications (such as infection) has been greatly reduced as a result of giving the earliest possible definitive neurosurgical intervention. Many men were killed and seriously injured during the war, but from this we have learned a great deal from these injuries which can be applied to similar situations in civilian life. The authors of these chapters are outstanding authorities in neurosurgery. This text will be of value to the neurosurgeon, general surgeon, and nursing personnel who will take care of these kinds of injured patients.

ARTHUR WINTER, M.D.

Obstetrics. J. B. Greenhill, M.D. 13th ed. Philadelphia, 1965, W. B. Saunders Company. Pp. 1246 with 1296 illustrations on 1193 figures, 54 in color. ($20.00)

This new edition of the famous Greenhill text has been modernized from the original text of Joseph B. DeLee, M.D. It continues in the same category of excellence as its predecessors. The latest issue includes subject matter which has been arranged in a progressive and easy-to-understand manner, starting from conception to and through the many normal and abnormal situations which confront the physician who is responsible for the pregnant female and her unborn child.

The text is a compilation of writings by 34 recognized authorities in obstetrics. The diagrams and photographs are clear and illustrative, although in many instances somewhat antiquated. The writing is vivid and concise. The reader may have some difficulty, however, in cross-indexing of subjects in the back of the text, but this is a minor drawback.

The volume belongs in the library of every specialist and should be available to any physician who does any obstetrics. James L. Breen, M.D.

Studies in Epidemiology: Selected Papers of Morris Greenberg, M.D. Edited by Fred B. Rogers, M.D. New York, 1965, Putnam. Pp. 411. ($8.50)

Unfortunate, indeed, are those among us whose narrow definition of epidemiology disposes them to dismiss this volume as apart from their line of interest. Far from being a limited exercise in "Who gave what to whom," these papers will be provocative reading for all who have associations with medicine and for whom the challenge of medicine is not alone treatment of individual cases of disease as they occur but the attempt to discover common patterns of disease and health which must hold the clues to prevention. Thus, the numerous papers which attest to Dr. Greenberg's origin as a pediatrician and continuing interest throughout his public health career in the diseases of children encompass not only progress in the control of communicable disease in this age group—notably poliomyelitis, staphylococcal infections, and measles—but the origin of congenital cardiac defects and problems of control of lead poisoning as well.

Thus, in the single chapter, Control of Communicable Disease, a stimulating protocol is available for reassessment of procedures and an indication of those areas to which their attention must be continually redirected. Certainly all who have wrestled with the problem of whether to give or withhold rabies vaccine when exposure is in question can enrich their own funds of information from the series of 297 patients reported receiving Semple or Duck-Embryo rabies vaccine in the New York City antirabies clinics.

The format chosen by the editor, Dr. Fred B. Rogers (who is the archivist of The Medical Society of New Jersey and the author of a highly readable monograph on medical history), is convenient in that he has grouped the studies according to their primary focus. Discussions of diseases which occur chiefly in community and institutional settings appear together: one section deals with specific viral and rickettsial diseases; another is devoted to immunology; and a final section deals with the epidemiology of congenital malformations. Shirley A. Mayer, M.D., M.P.H.

Management of Juvenile Diabetes. H. S. Traisman, M.D. and A. L. Newcomb, M.D. St. Louis, 1965, Mosby. Pp. 147. ($12.75)

In the preface, the authors start by saying: "Diabetes mellitus is a chronic disease of inconvenience. Proper management of the child . . . ensures normal growth . . . and delays the onset of the degenerative complications." The first sentence is an interesting description; the second is a statement devoutly to be wished for. The preface goes on to state that the purpose of the book is "to provide a concise, practical method of management. . . . The monograph is written primarily for the pediatrician and the general practitioner." This is, indeed, a noble purpose, considering the shyness of these sects of doctors in tackling this rather complex problem.

The chapter on diagnosis is outstanding in detail and completeness, mentioning the important differential from salicylate poisoning and some other rarer conditions. The outline of the treatment of acidosis, excellent in detail, is enough to frighten the pediatrician and general practitioner for whom it was written. A chapter called "Six Hour Management" is a practical method of treatment under special stress situations, such as severe illness and contemplated surgery in uncontrolled diabetes.

The objectives of control stated by the authors are in the middle of the road between the strict normoglycemic regimes and the freer criteria advocated by other authors. Your reviewer feels, however, that the chapter on diet management (written by a dietitian, and probably comprehensible only by other dietitians) is incongruous with the broad objectives of management stated by the good doctors. Statements such as "only vanilla ice cream" typify a rather conservative and strict dietary approach.

A series of appendices includes instructions for nurses on nursing procedures, collection and testing of urines, and teaching technics for insulin administration. Also offered is a detailed set of instructions on calculating fluid and electrolyte requirements, with the very important statement: "One must realize that the many different schemes of fluid and electrolyte therapy are all gross approximations."

In spite of spotty production on other details, the book has so many very useful and sometimes amazingly complete discussions that it is recommended as a useful reference for anyone faced with the problems of the juvenile diabetic. Everett O. Bauman, M.D.

A History of Pathology. Esmond R. Long, M.D. New York, 1965, Dover Publications. Pp. 199. ($2.00)

This volume should be in the library of every physician. The paperback edition covers not only the history of pathology, but the history of medicine through antiquity, the Middle Ages, the Renaissance, and more recent centuries. The text outlines the contributions of such men as Malpighi, Fernel, Morgagni, Bichat, Cruvelhier, Pare, Hunter, and Bright with special chapters devoted to Rokitansky and Virchow. Also reviewed is the development of immunology and bacteriology. An appendix covers trends since 1963. This section is also highly informative. One recalls the memorable words of Bichat: "Dissect in anatomy, experiment in physiology, follow the disease and make the necropsy in medicine; this is the three-fold path, without which there can be no anatomist, no physiologist, no physician." This merits repetition in view of the rise of many cults which would short-cut the academic curriculum and still offer the title of Physician.

The author is to be commended for his reproduction of the portraits of famous men who have contributed to the history of pathology as well as illustrations of some of their work and of the building which housed the Wurzburg Pathologic Institute in Virchow's time. The contrast with modern pathologic institutes can be appreciated.

This volume not only merits a second edition but should have repeated reading. It gives equal accent to the mistakes and successes of our medical forebears, whose search for truth constitutes one of man's best accomplishments. T. K. Rathmell, M.D.

Current Psychiatric Therapies 1965. Edited by Jules H. Masserman, M.D. With chapters by 39 other contributors. New York, 1965, Grune and Stratton. Pp. 306 (Price not stated)

In this compact book, psychiatry seems to have paused to catch its breath and take a long view. The contributors have packed into 300 pages an extraordinary variety of perspectives, positions, and data. There is a chapter on the state of East Africa (with some rather frightening observations on South Africa thrown in), a little monograph on community psychiatry, a treatise

on family therapy, a discussion of rehabilitative techniques, a review of psychiatric aspects of childhood and adolescence, and several chapters on individual therapy. Although the book is supposed to deal with "therapies" in general, the present volume concentrates largely on psychotherapy. In fact, even where medication is recommended (as, for instance, in Jackson Smith's chapter on the treatment of alcoholism), it appears in a section labelled "individual psychotherapy." The scope of this volume is broad, the contributors write vividly, and the entire book offers an unusual kaleidoscope of psychiatry today.

ABRAHAM LEFF, M.D.

Narcotics. Edited by D. M. Wilmer, Ph.D. and G. G. Kassbaum, Ph.D., with 19 contributors. New York, 1965, McGraw Hill. Pp. 288 plus index. ($13.50)

This volume brings together the viewpoints of 19 authorities as presented at the National Narcotics Conference of 1963. The material, already out-dated, offers no solution to our drug problem. However, it does cover all phases of narcotic habituation from medical to legal. In their attempt to present all points of view, the editors offer something for everybody, and thus complicate everything without reaching any conclusions. They propose, discuss, discard many old and new theories so that one is left with the feeling that nothing concrete is offered. Perhaps, there *are* no answers. Some contributors say that the whole American image of drug addiction requires overhauling.

No mention is made of barbiturate addiction, glue sniffing, or of the abuse of tranquilizers. This serious issue is one where again we have been unsuccessful in controlling a problem. Yet this is ignored in the Wilmer-Kassbaum book.

The book is small and over-priced. Thirty-five of its 288 pages are devoted to lists of references. The work of 19 different authors, its style is not uniform. There is repetition, and the writing varies from clearness to obscurity. However, one conclusion does stands out. More research and more information are absolutely needed. The true value of this book lies in the fact that it reveals the confused, incomplete state of our knowledge and indicates how far we still are from solving the dilemma of our drug addiction problem.

THEODORE A. ANDERSON, M.D.

Aneurysms And Arteriovenous Anomalies Of The Brain; Diagnosis And Treatment. J. Lawrence Pool, M.D. and D. Gordon Potts, M.D., New York, 1965, Hoeber. Pp. 463. ($19.50)

Despite recent advances in the area of cerebral vascularity, no major treatise has appeared in this country since 1952. The availability of this comprehensive and timely text thus serves a major need in the neurologic sciences. Early surgery to prevent a second (and all too often—fatal) hemorrhage is stressed.

The 271 illustrations beautifully complement the text. Especially commendable are the radiologic photographs. The printing and general format are pleasing. Most welcome are the succinct summaries at the end of each chapter. The bibliography covers 21 pages and includes most of the significant literature. Chapter 10, "Subarachnoid Hemorrhage in Pregnancy," will serve well those who find themselves with the heavy responsibility for the care of these patients. All aspects of treatment are well covered and no evidence of concealed bias is found. This authoritative work will inevitably find its way into the libraries of all physicians and hospitals who deal with these lesions; and, most assuredly, will gather no dust there.

GEORGE L. BECKER, JR., M.D.

Comparative Biochemistry of Arginine Derivatives. Edited by G. E. W. Wolstenholme, M.B. and M. P. Cameron, M.A., Boston, 1965, Little, Brown & Co. Pp. 103. ($2.95)

Arginine is generally considered to be an indispensable amino acid. It is indeed the most basic amino acid found in protein. It plays a prime role in nitrogen metabolism by virtue of its direct involvement in the biosynthesis of creatinine and urea. This book deals with recent discoveries concerning the metabolism of arginine, particularly in microbial organisms and in invertebrates. In addition to several well-written papers on the phylogenetic aspects of arginine metabolism, the discussions of 21 outstanding investigators are recorded. Very little discussion is focused on the mammalian metabolism of arginine or on the clinical aspects of this amino acid. Research biochemists and physiologists will find this book interesting.

HAROLD M. BATES, PH.D.

Anatomy and Surgical Technic of Groin Dissection. J. S. Spratt, M.D., William Shieber, M.D., and B. M. Dillard, M.D. St. Louis, 1965, Mosby. With 16 tables and 37 figures. Pp. 97. ($9.75)

The goal of the authors is to define the anatomic extent of the ilioinguinal lymph nodes and the surgical technic for their safe and complete removal and to show if, when, and how the operation alters the natural progression and lethality of the cancers; and to consider the morbidity factors associated with this operation, identifying the components that minimize morbidity.

The authors have accomplished these goals, succinctly and lucidly. The anatomic drawings are adequate and the lymphangiograms are excellent. The technic of groin dissection is written in such vivid detail that this book could be used as a dissection manual by the medical student in the anatomy laboratory. This volume would be a valuable addition to the library of every surgical residency program. The surgeon who does radical groin dissection only rarely will benefit greatly by spending an hour or so reviewing this monograph the night before the operation.

HENRY REICH, M.D.

Fractures and Soft Tissue Injuries. The Committee on Trauma, American College of Surgeons. Ed. 2. Philadelphia, 1965, Saunders. Pp. 365, illustrated. ($7.50)

This volume merged the ACS Outline of The Treatment of Fractures with the *Early Care of Acute Soft Tissue Injuries*. It is the work of a large committee of the American College of Surgeons, well versed in the treatment of soft tissue injuries, fractures, and the complications produced by such injuries. Well outlined are the principles to be considered when dealing with trauma. The first chapters review the assessment of the situation and the determination of the priority in multiple injuries. Prevention of complications and the treatment of shock are emphasized.

Another section sets forth principles and outlines the treatment of these injuries. The complications that plague the surgeon are vividly reviewed. Technical details in closed or open treatment of fractures are not included. However, the authors do list indications and contraindications to the procedures suggested for each lesion.

In the section dealing with soft tissue injuries, the physician is given sufficient guidance to permit the evaluation of the situation and the institution of emergency as well as definitive treatment. As a guide in the care of injuries, this volume is highly recommended.

CHARLES I. NOERL, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

March, 1966 VOL. XXXIX, NO. 3

CHEMOPROPHYLAXIS IN CHRONIC PULMONARY EMPHYSEMA

Daily chloramphenicol reduced significantly the incidence of H. influenzae in sputum of patients with chronic bronchitis and emphysema, but only slightly reduced the number of acute clinical exacerbations in a group of patients with chronic obstructive pulmonary disease.

A study was undertaken to extend earlier observations on the bacterial flora of the sputum of patients with chronic bronchitis and emphysema, and to assess the role of *Hemophilus influenzae* in acute episodes occurring in these conditions.

Selected for the study were 40 patients from the Emphysema Section of the Bellevue Hospital Chest Clinic. All had clinical and physiologic evidence of chronic bronchial obstruction and emphysema. All but three of the patients were men and the majority were too incapacitated by breathlessness or cough to maintain a job. The three women were able to do housework only.

On the basis of sputum examinations over a period of weeks, patients were grouped according to the presence or absence of *H. influenzae* in the sputum and according to whether they had had previous prophylactic therapy.

The patients were randomly divided into two groups, 21 being placed on chloramphenicol and 19 being given a placebo. During the treatment period, from four to 14 months, all patients submitted weekly sputum specimens, were interviewed briefly, and received their weekly supply of medicine.

While being treated, the 19 patients on placebo had 41 infections and the 21 on chloramphenicol had 31.

During treatment, an immediate and persistent change in flora occurred in five patients. *H. influenzae* disappeared from the sputum of three patients in whom it had been observed intermittently before therapy, and in two patients in whom it had been present consistently before treatment. In one of these, pneumococci, which had been present sporadically the previous year, were subsequently isolated from almost every specimen during treatment with chloramphenicol, yet remained susceptible to the drug.

H. influenzae occurred significantly less frequently in the sputum of the chloramphenicol-treated patients than in the sputum of the placebo patients. The frequency of isolation of this microorganism did not follow any seasonal pattern, but it was found more often in purulent than in nonpurulent sputum.

The incidence of pneumococci in the sputum increased in both the patients taking the placebo and in those treated with chloramphenicol. This microorganism was present throughout the year regardless of treatment and was found more frequently in purulent than in nonpurulent sputum.

Staphylococcus aureus was isolated slightly more frequently during the treatment period than in the pretreatment period. The incidence of this microorganism was higher in patients who were hospitalized at some time during the study than in those who were not hospitalized.

ANNE L. DAVIS, M.D.; EVELYN J. GROBOW, M.D.; THERESA KAMINSKI, B.A.; RALPH TOMSETT, M.D., and JOHN H. MCCLEMENT, M.D., *The American Review of Respiratory Diseases*. December, 1965.

Gram-negative enteric rods appeared with about equal frequency in the sputum of both groups of patients during the treatment period. Beta hemolytic streptococci were isolated from about 5 per cent of the cultures from the placebo patients and from those of the chloramphenicol patients.

As for pulmonary function, although the patients receiving chloramphenicol showed slight worsening during therapy, the differences in lung volumes, maximal breathing capacity measurements, and arterial blood gases before and during treatment were not considered significant.

Studies Compared

The results of the daily, long-term prophylactic regimen with chloramphenicol confirm, in general, the findings of a previous trial with long-term, intermittent tetracycline therapy.

While daily administration of chloramphenicol appeared to reduce the number of infections, subjective improvement was not striking and was less frequent than in the tetracycline study.

The reduction in the incidence of *H. influenzae* in the sputum of the patients receiving chloramphenicol was slightly more striking than that obtained with the intermitent tetracycline regimen. However, with tetracycline the incidence of pneumococci was significantly lowered in contrast to the increase in pneumococcal isolations among the patients receiving chloramphenicol.

The role of *H. influenzae* in patients with chronic bronchitis and emphysema is still controversial. That it may be an etiologic factor in the acute exacerbations of these patients was suggested by the fact that, although *H. influenzae* was present in only 11 per cent of the sputum cultures from patients receiving chloramphenicol, it was present as "persistent" flora in almost 23 per cent of the infections in this group. Furthermore, in the patients treated with chloramphenicol, the incidence of *H. influenzae* in the sputum, expressed as per cent of cultures, was twice as high in the patients having exacerbations as in those who had never had acute infections during the year. This relationship was not found in the patients receiving placebo.

Perhaps prophylactic chloramphenicol alters the sputum flora in such a way that, with acute exacerbations, *H. influenzae* is somehow allowed to assume more prominence than in patients whose flora has not been altered by a prophylactic antimicrobial, or perhaps the failure to eliminate *H. influenzae* with chloramphenicol identifies a group of patients who are at greater risk of recurrent infection.

That pneumococcus may be of importance in the exacerbations of chronic bronchitis and emphysema is suggested by the fact that, in the patients treated with the placebo, the infection rate in those who had pneumococci at some time was considerably higher than in those who had never had this microorganism isolated from their sputum. Furthermore, most of the patients who had acute infections had pneumococci at some time during the study, whereas only a third of the patients who had never had infections had the microorganism.

In the majority of patients, long-term chemoprophylaxis is probably not justified. If it is continued indefinitely, it is expensive. It has been found, too, that if it is discontinued after six months, approximately 50 per cent of the patients revert to their pretreatment state. Furthermore, evidence is accumulating to suggest a non-bacterial etiology of most acute exacerbations.

New Jersey Tuberculosis and Health Association
15 East Kinney Street, Newark, New Jersey 07102



the sedentary life is often the seat of low back pain

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

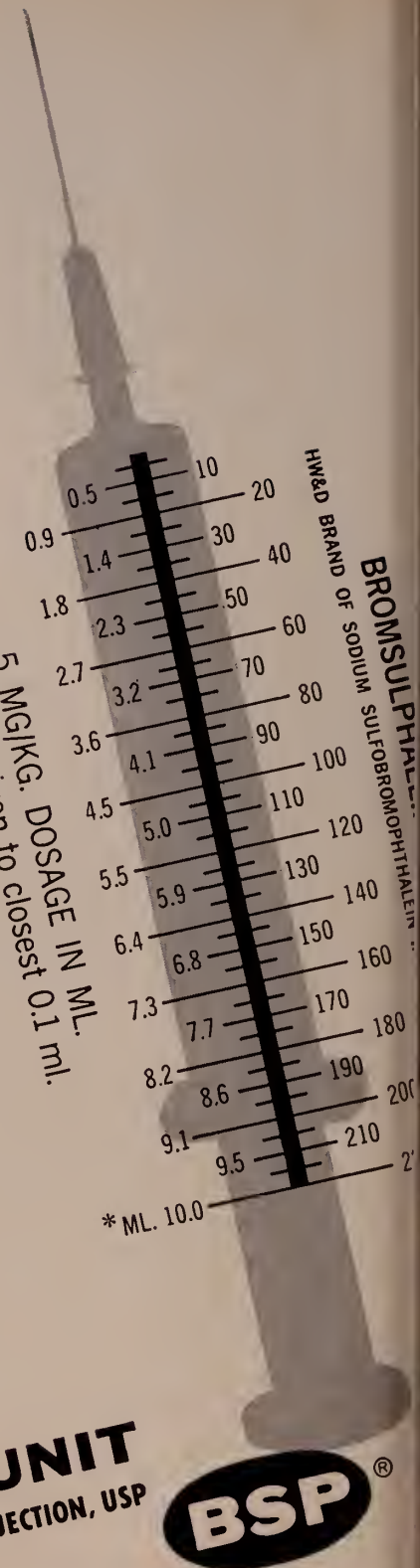
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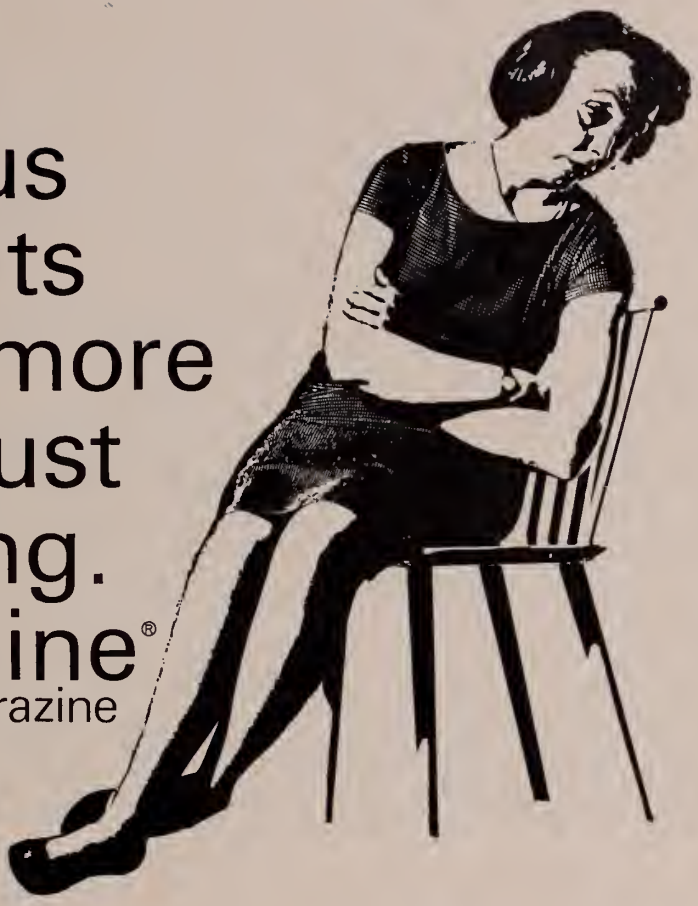
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PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or disfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

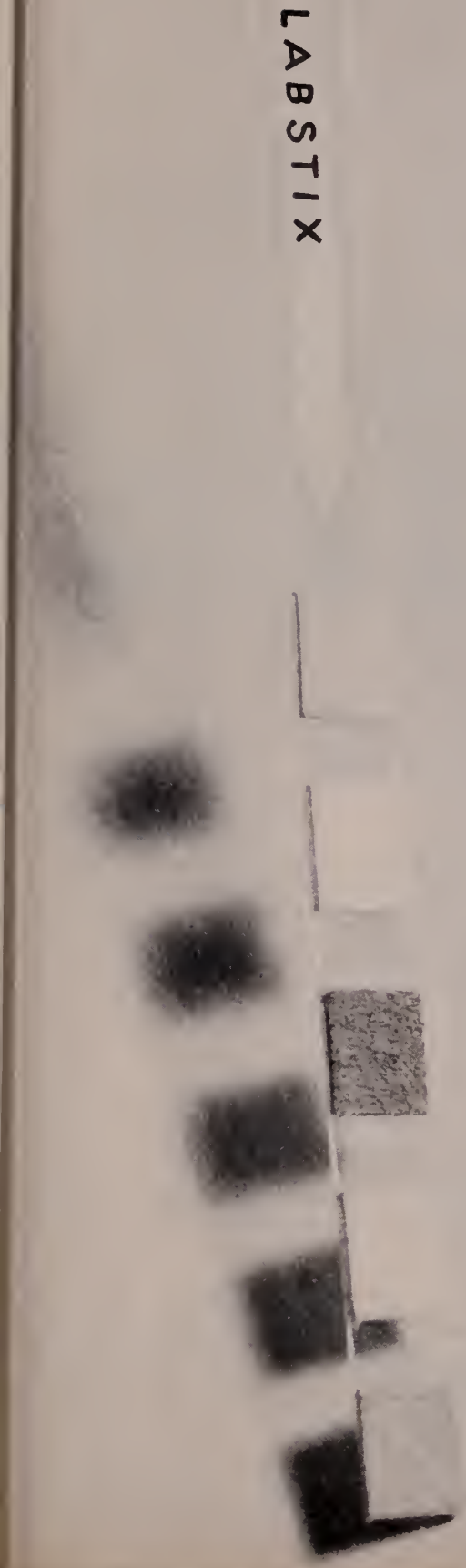
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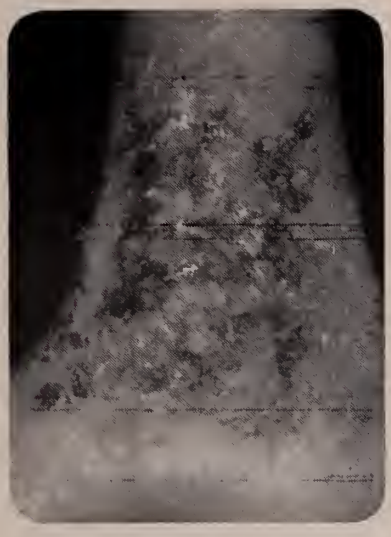
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Packages: Tubes of 5 Gm. and 15 Gm.; ½ lb. jar.

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Our policy, approved and recommended by The Medical Society of New Jersey is broad enough to cover:

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ontraindications
dema, danger of cardiac decompensation; story or symptoms of peptic ulcer; renal, epatic or cardiac damage; history of drug llergy; history of blood dyscrasia. The drug ould not be given when the patient is se-le, or when other potent drugs are given oncurrently. Large doses are contraindiated in patients with glaucoma.

ecautions
otain a detailed history and a complete ysical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et al.: Angialagy, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

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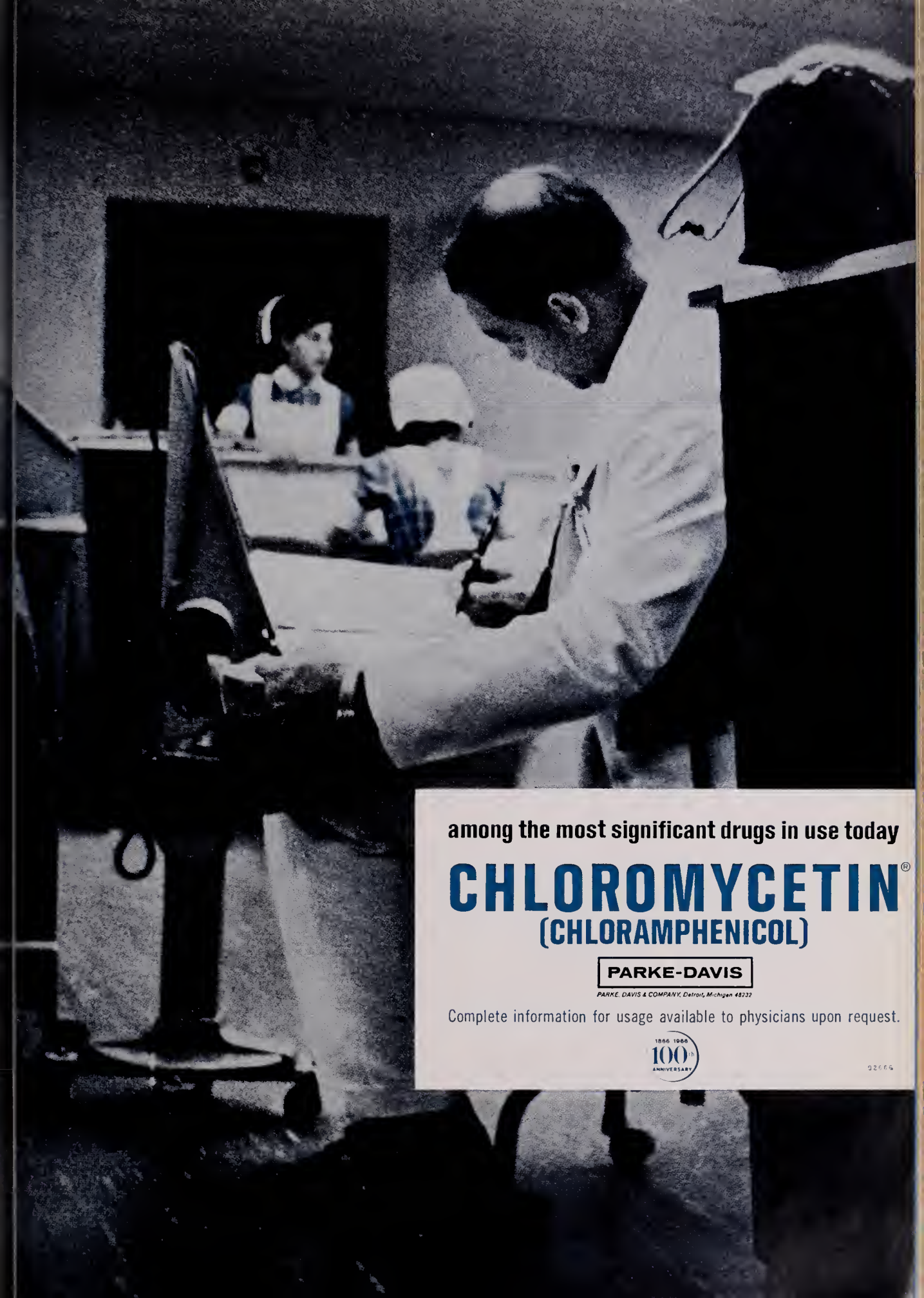
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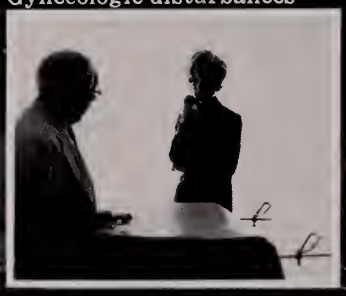
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CONTENTS • Pages 115 to 152

EDITORIALS
But Especially This Year . . . 115
The Duty To Become Involved . . . 115
Jet-Propelled Smallpox . . . 116

ANNUAL MEETING PROGRAM
Bicentennial Convention . . . 117
Daily Schedule . . . 118
Bicentennial General Assembly . . . 119
Reference Committees . . . 120
House of Delegates . . . 121
Offices To Be Filled by Election . . . 121
General Session on Medicare . . . 123
Scientific Program . . . 124
Technical Exhibits . . . 133
Bicentennial Dinner-Dance . . . 137
History of Medicine Exhibits . . . 138
Woman's Auxiliary Annual Meeting . . . 140

STATE ACTIVITIES
Second Injuries and Employment of Handicapped . . . 141
New Rule on Malpractice Claims . . . 141
Delays in Signing Death Certificates . . . 144
The New History . . . 144
Report Your Adverse Drug Reactions . . . 145
For Your Travelling Patients . . . 145
Membership Directory . . . 52A

BICENTENNALIA . . . 146

OBITUARIES . . . 147

ANNOUNCEMENTS . . . 148

BOOK REVIEWS . . . 149

RESPIRATORY DISEASE ABSTRACTS . . . 151

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In its bicentennial year, the official seal of The Medical Society of New Jersey shares prominence with the official seals of those component societies celebrating their sesquicentennial anniversaries. According to the proceedings of the New Jersey Historical Society ("An Outline of the History of the Medical Society of New Jersey to 1900"), the first county medical societies organized in 1816 were: Somerset, May 21; Essex, June 4; Cumberland, June 6; Middlesex and Morris, June 11; and Monmouth, July 24.

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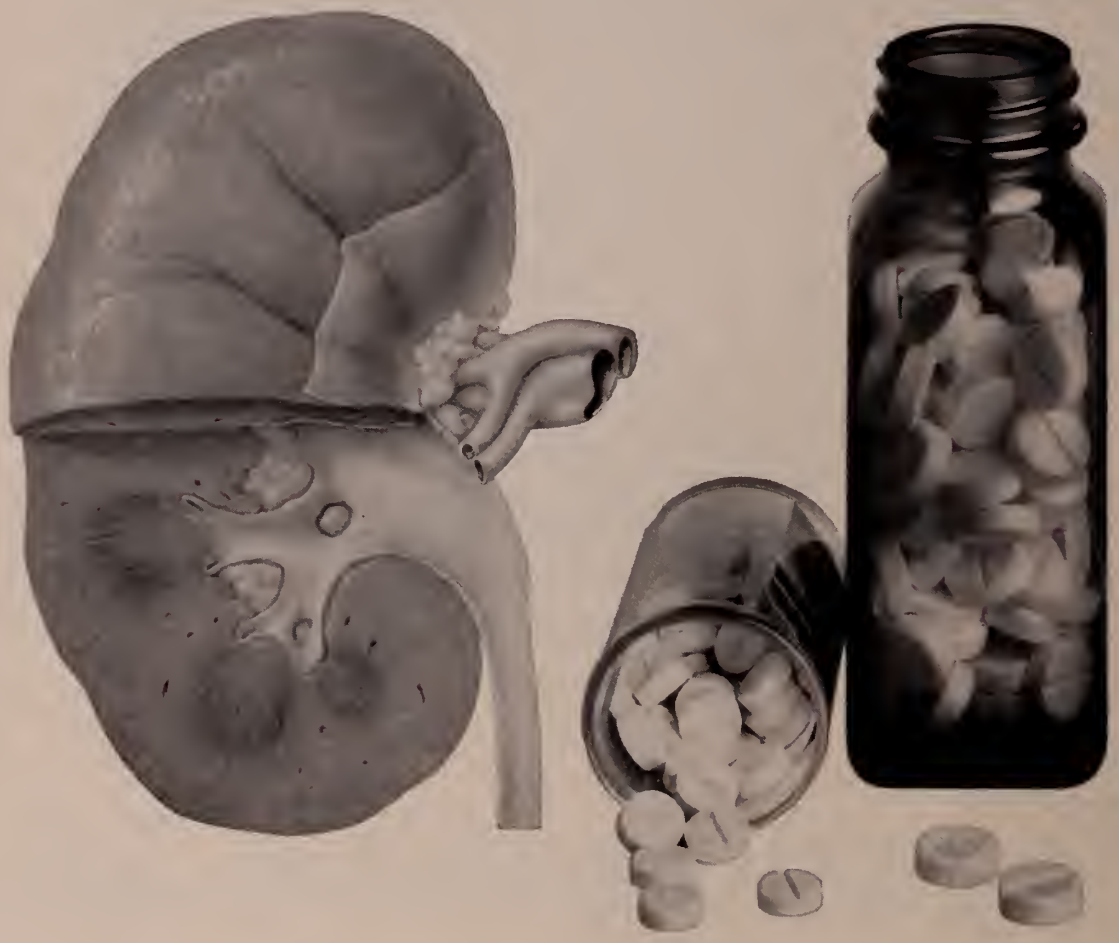
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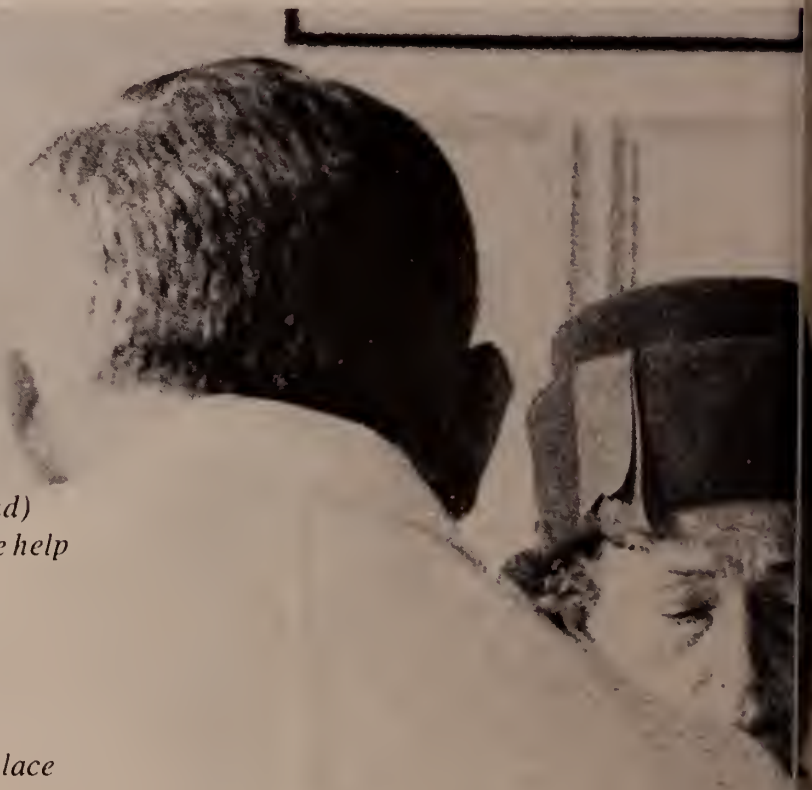
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Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

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Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

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Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

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Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.

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BSP® DISPOSABLE UNIT

A RELIABLE, PROVEN PRODUCT . . .

The BSP test, introduced in 1925, remains one of the most sensitive laboratory procedures available for determining hepatic function.

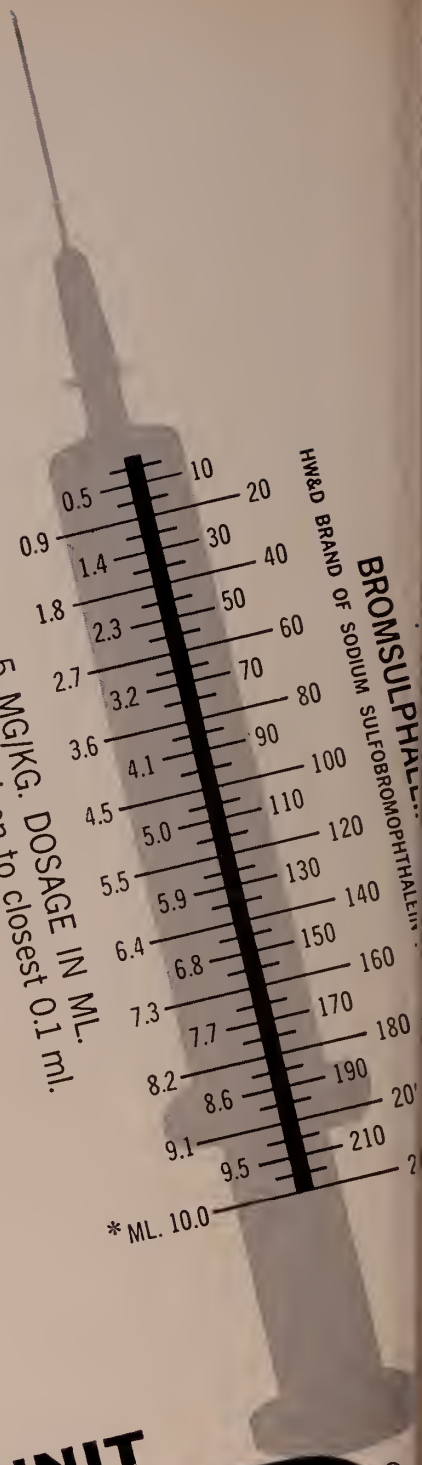
A STERILE, CONVENIENT PUT-UP . . .

Each BSP Disposable Unit contains: a sterile, glass, disposable syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of Bromsulphalein.

The BSP unit is designed for maximum patient protection. The precalibrated syringe makes weight calculations unnecessary and provides for proper dosage regardless of patient-weight.

ECONOMICALLY PACKAGED . . .

Prepared for economic unit dispensing, this completely disposable put-up affords a savings in time and labor—the most costly commodities.



BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

HYNSON, WESTCOTT & DUNNING, INC.

BALTIMORE, MARYLAND 21201

(BSP02)



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

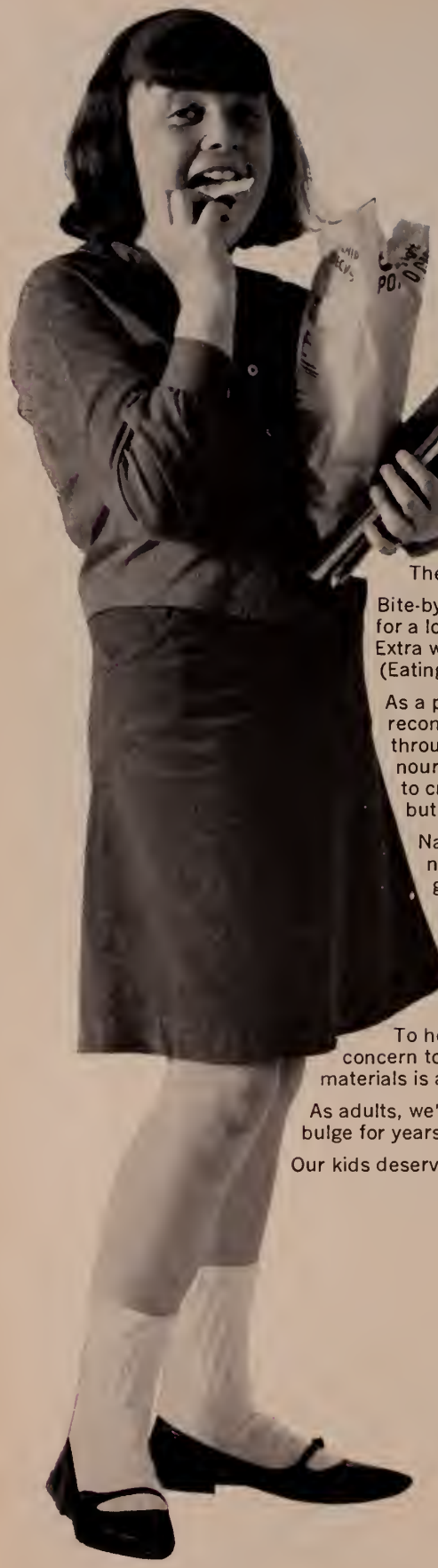
Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.







Our kids deserve a better break

There's the cola break.

The after-school break.

The snack during the TV-break.

Bite-by-bite it adds up to extra weight for a lot of our young people. Extra weight they don't need, and won't lose. (Eating habits are hard to break.)

As a professional you can help by recommending long-range weight control through sensible eating habits and nourishing foods. It's not likely to create new habits overnight, but it is a beginning.

Naturally, balanced diets and nourishing, palatable dairy foods go together. They always have.

Project Weight Watch has been initiated to assist you. Its scope is nationwide, its purpose is to focus professional attention on the problem.

To help you translate your concern to your patients, a portfolio of materials is available. Send for it.

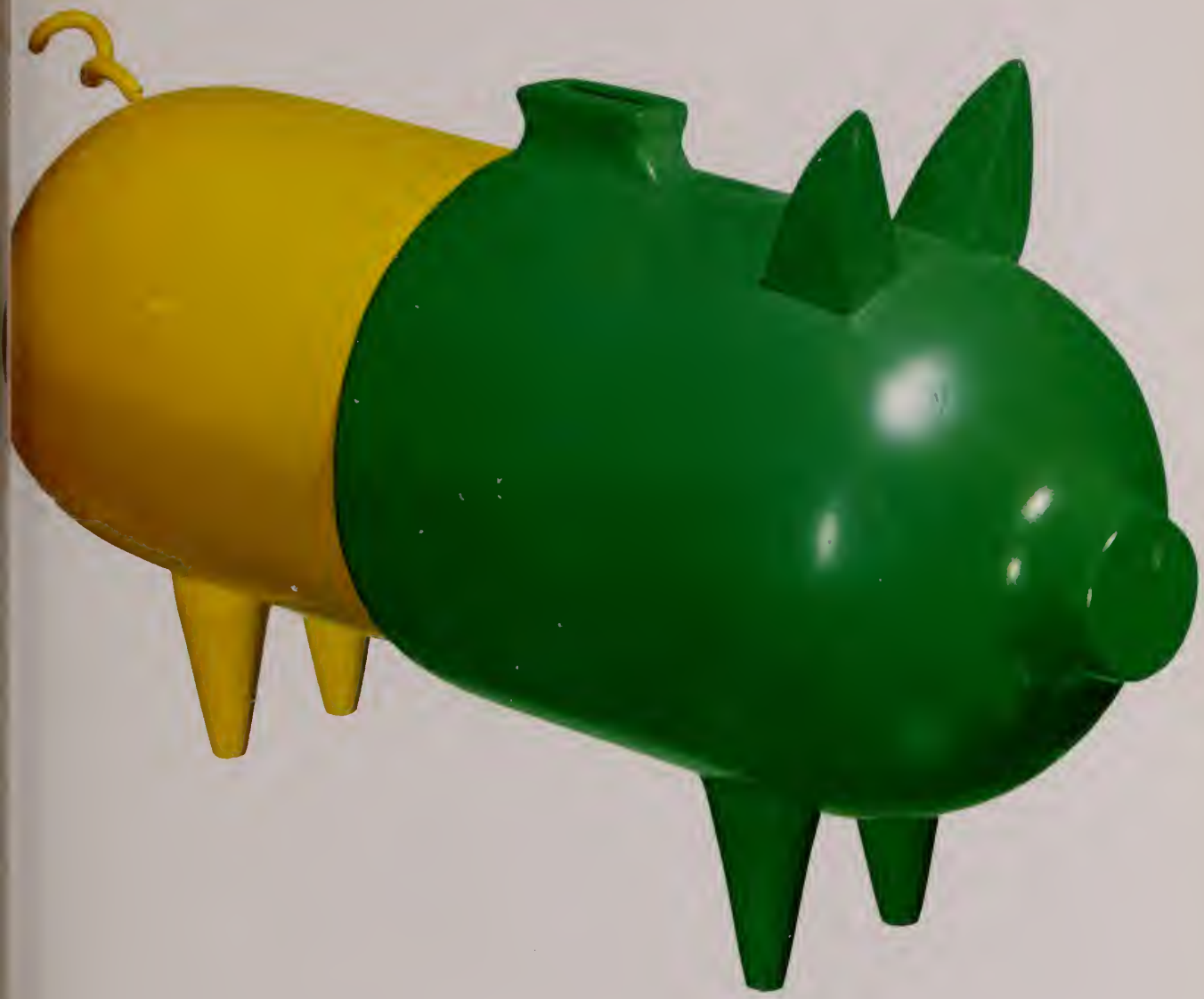
As adults, we've been battling the bulge for years.

Our kids deserve a better break.

PROJECT WEIGHT WATCH

Dairy Council OF NORTHERN NEW JERSEY, Inc.

100 HALSTED STREET • EAST ORANGE, N. J. 07018



ECONOMY

When you prescribe or recommend Allbee with C, you can be sure your patient is getting a rational, specific multivitamin formulation at an economical price. The potent formula is sensible and simple. It contains therapeutic amounts of the water-soluble B and C vitamins. These vitamins are expended rapidly in the body and need to be replenished frequently. There are no extraneous factors, no frills in Allbee with C. It's the no-nonsense vitamin in the yellow and green capsule that always gives your patient his money's worth.

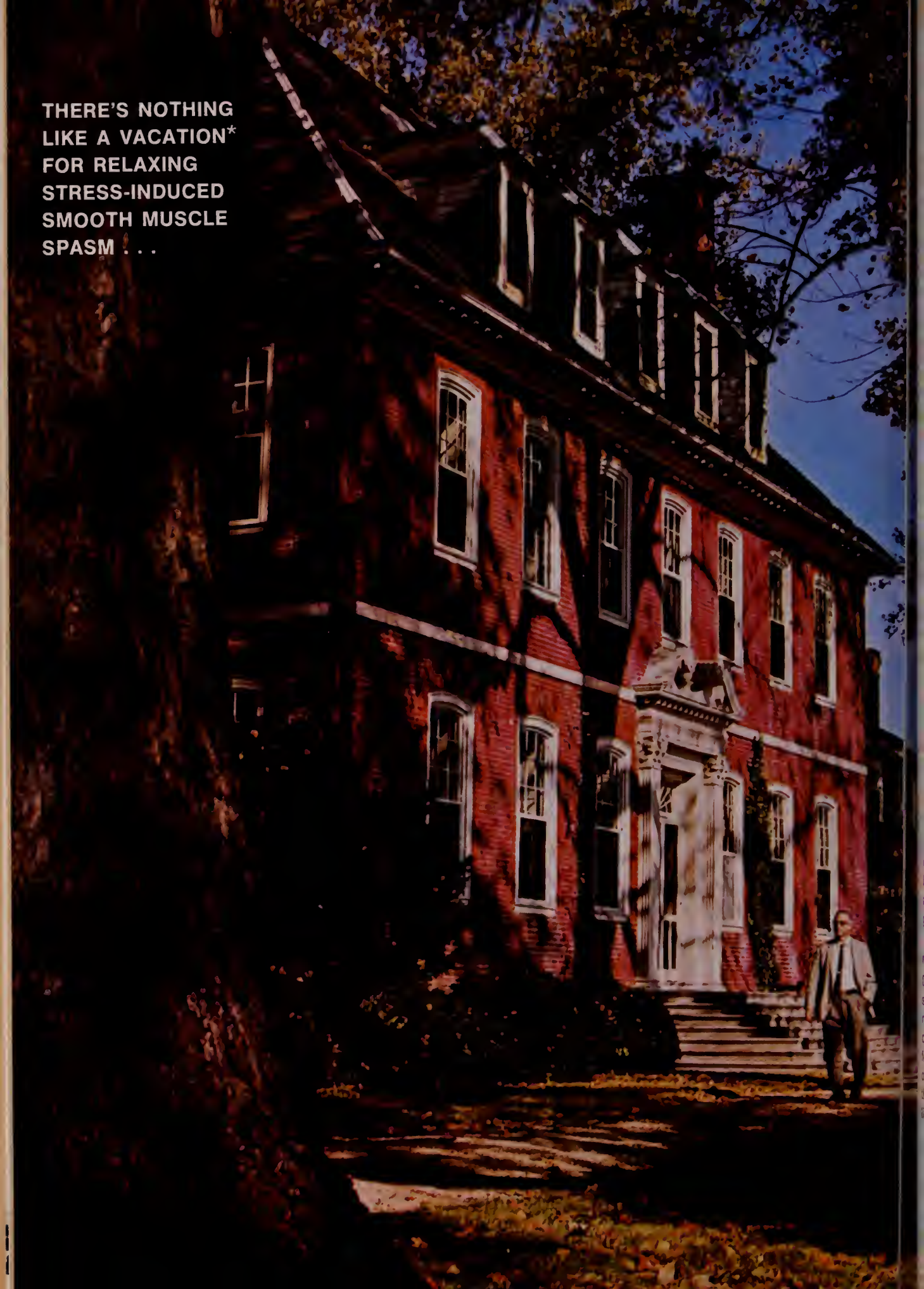
Each capsule contains: Thiamine mononitrate (B_1), 15 mg.; Riboflavin (B_2), 10 mg.; Pyridoxine hydrochloride (B_6), 5 mg.; Nicotinamide, 50 mg.; Calcium pantothenate, 10 mg.; Ascorbic acid (vitamin C), 300 mg.

A. H. ROBINS COMPANY, INC.,
RICHMOND, VIRGINIA 23220

A·H·ROBINS

—a good reason for AHR

ALLBEE® WITH C


THERE'S NOTHING
LIKE A VACATION*
FOR RELAXING
STRESS-INDUCED
SMOOTH MUSCLE
SPASM . . .

. . . NOTHING, THAT IS,
EXCEPT THE SEDATIVE-ANTISPASMODIC
BENEFITS OF

DONNATAL®

There's nothing quite like a vacation to ease the pressures of the modern, "workingday" world. And for the patient who can't get away from it all, there's nothing quite like Donnatal to relax stress-induced smooth muscle spasm. For 31 years it has been the antispasmodic-sedative most often prescribed for relieving functional disturbances of tone and motility of the gastrointestinal tract.

belladonna alkaloids in optimally balanced ratio

In Donnatal, natural belladonna alkaloids are rationally balanced in a specific, fixed ratio that provides "the greatest efficacy with the smallest possible dose."[1] They avoid the clinical uncertainties of the variable tincture and extract of belladonna, and are considered superior in range of action to atropine alone.[2] Furthermore, they are generally recognized as being more effective than the synthetics for relieving visceral spasm.

phenobarbital for sedation

Years of clinical use have established phenobarbital as one of the most efficient and highly regarded sedatives. In fact, for general sedation it is the drug of choice.[3] In Donnatal, phenobarbital potentiates the spasmolytic effects of the belladonna alkaloids, lessening emotional tensions and checking the neurogenic impulses that trigger GI disorders.

more than 24 indications in PDR

Donnatal has withstood the test of time to become the classic sedative-antispasmodic because of its unsurpassed effectiveness, safety, economy, uniformity of composition, and dosage convenience. Its widespread acceptance and usage by the profession can also be attributed to its versatility in treating disorders characterized by smooth muscle spasm. There are more than two dozen distinct and separate indications for Donnatal listed in the current PDR.

IN EACH TABLET, CAPSULE, OR (5 cc.) OF ELIXIR

hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide	0.0065 mg.
phenobarbital	(1/4 gr.) 16.2 mg.

(warning: may be habit forming)

IN EACH EXTENTAB

hyoscyamine sulfate	0.3111 mg.
atropine sulfate	0.0582 mg.
hyoscine hydrobromide	0.0195 mg.
phenobarbital	(3/4 gr.) 48.6 mg.

(warning: may be habit forming)

BRIEF SUMMARY: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma, or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease, or a hypersensitivity to any of the ingredients.

REFERENCES: 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

*This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

A. H. ROBINS COMPANY, INC., RICHMOND, VA.

A·H·ROBINS

IMPORTANT FACTS

about

Professional Liability Coverage

Insurance that only covers claims based on the rendering of, or failure to render, professional services, or arising out of malpractice error or mistake in rendering professional services, is no longer adequate.

Our policy, approved and recommended by The Medical Society of New Jersey is broad enough to cover:

(1) the non-negligent as well as the negligent claim, such as arising out of duties as committee member in your society or hospital.

(2) The financial loss to a physician in attending trial as a defendant in protracted litigation.

(3) punitive damages for libel or slander.

This program, which was designed with The Medical Society of New Jersey and its legal counsel, and operated by a cooperative Loss Control Program, offers this broad protection, security and continuity of coverage.

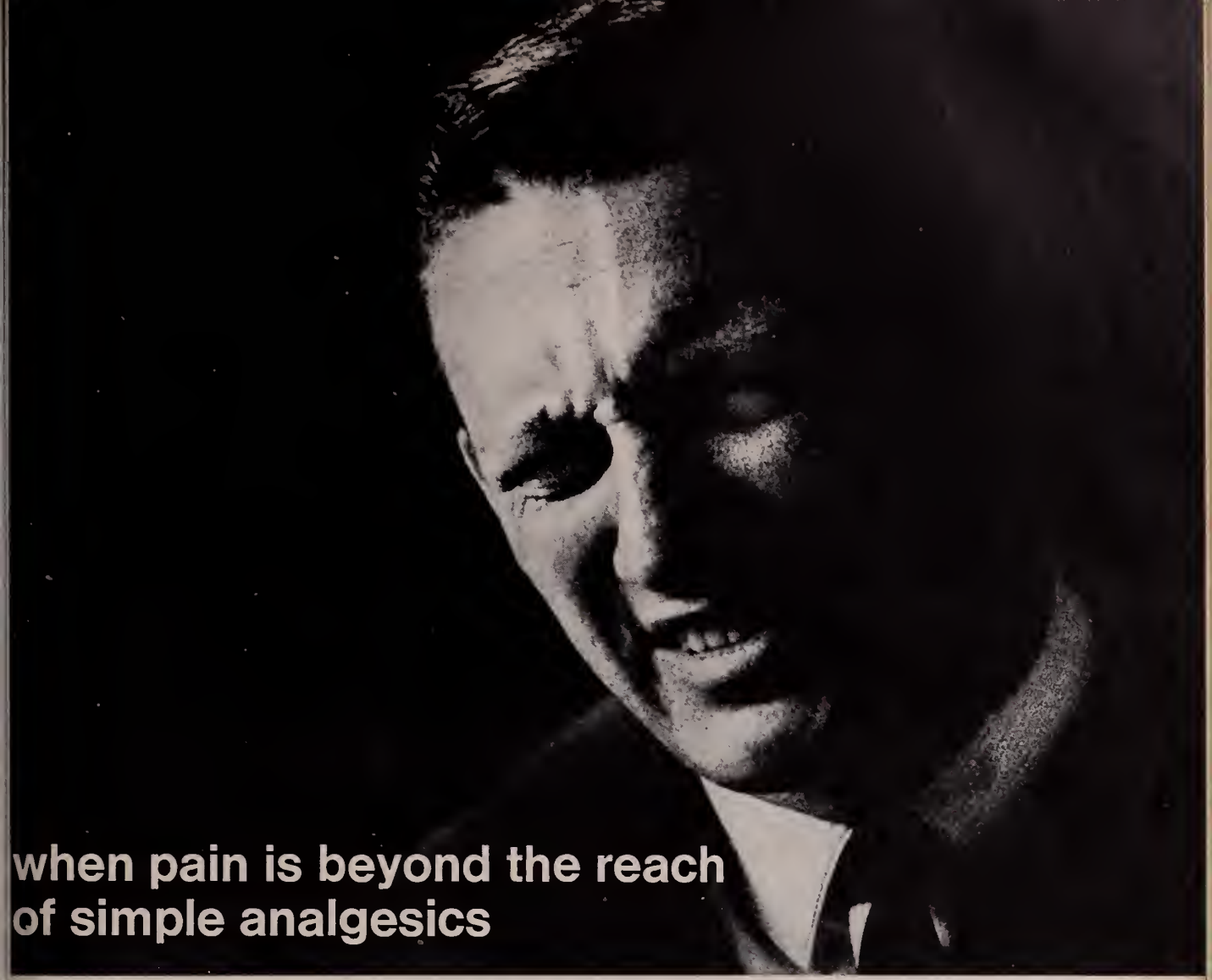
Complete protection should not
be controlled by price.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

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Joseph A. Britton, Manager ORange 3-2575
Home Office: Wakefield, Mass.



when pain is beyond the reach of simple analgesics

In the management of mild to moderate pain, give your patients comprehensive relief. TRANCO-GESIC extends the range of usefulness of aspirin by dimming pain perception—and *also* reducing mental and muscle tension.

TRANCO-GESIC®

tablets

chlormezanone 100 mg. with aspirin 300 mg.

subdues the major contributors to pain:

- pain perception
- mental tension
- muscle tension-spasm

TRANCO-GESIC is so well tolerated it can be prescribed for anyone who can take aspirin. It is non-narcotic, and free from dangers of addiction, habituation, or dependence. TRANCO-GESIC is effective in all types of mild and moderate pain. Of 862 patients who were treated with chlormezanone and aspirin for various disorders, 88% reported excellent or good pain relief.[1]

Side effects have been minor. Occasionally gastric distress, weakness, sedation or dizziness occur. Reversible cholestatic jaundice has been reported on rare occasions. However, in 4,653 patients treated with chlormezanone, 97.7% had *no* side effects.[1] *Contraindication:* just one: sensitivity to aspirin. *Dosage:* Adults, usually 2 tablets three or four times daily. Children (from 5 to 12 years), 1 tablet three or four times daily.

1. Collective studies, Department of Medical Research, Winthrop Laboratories.

Winthrop WINTHROP LABORATORIES, NEW YORK, N. Y. 10016

Thanks to Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

she can say "No thank you" to the crêpe suzette.

'Dexamyl' does more than most anorectics. Because it curbs appetite *and* lifts mood, 'Dexamyl' can encourage the discouraged dieter to stay on her diet.

The mood lift with 'Dexamyl' can make the difference between the success or failure of her diet plan.

Formulas: Each 'Dexamyl' Spansule® Capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

Before prescribing, see SK&F product Prescribing Information.

Smith Kline & French Laboratories SK&F





In Fractures: B and C vitamins are therapy

Stress formula vitamins are a key factor in bone and tissue regeneration. To meet the increased metabolic demands, STRESSCAPS offers therapeutic amounts of B and C vitamins as an aid to smoother convalescence and earlier rehabilitation. In fractures, as in many other conditions of physiologic stress, STRESSCAPS vitamins are therapy.

Each capsule contains:

Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

STRESSCAPS®

FOR PROFESSIONAL RECOMMENDATION ONLY

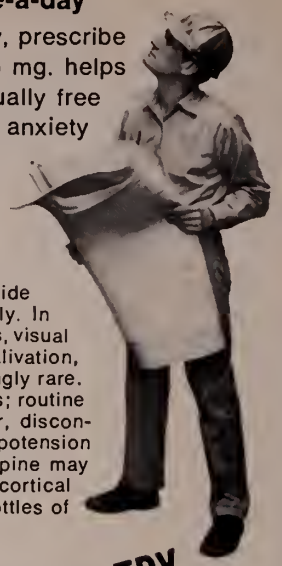
Stress Formula Vitamins Lederle

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

7283-4

Blueprint for dealing with tension due to stress—Prolixin—once-a-day

For the patient who must be on the job mentally as well as physically, prescribe Prolixin. The prolonged tranquilizing action of as little as one or two mg. helps him cope with tension all day long. Markedly low in toxicity and virtually free from usual sedative effects, Prolixin is effective in controlling both anxiety associated with somatic disorders and anxiety due to environmental or emotional stress. Patient acceptance is good—because Prolixin is low in cost, low in dosage and low in sedative activity. Prescribe Prolixin.



Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

PROLIXIN®

THE SQUIBB TRANQUILIZER

SQUIBB FLUPHENAZINE HYDROCHLORIDE

SQUIBB Squibb Quality – the Priceless Ingredient



Because cerebrovascular insufficiency can be controlled

...help the older patient enjoy life with less confusion, defects in memory, dizziness, weakness, fatigue and decreased activity by maintaining the cerebral blood flow.

Administration and Dosage: Two sublingual tablets three times a day until definite improvement is achieved. This usually occurs within four weeks. Maintenance dosage of one sublingual tablet three times a day is then established to continue this improvement.
Precautions: Hydergine sublingual tablets have not been found to produce serious side effects even in doses far beyond the ones recommended. Some nasal stuffiness due to adrenergic blockade, transient nausea or gastric disturbances have been reported with high dosages.
Supplied: Hydergine Sublingual Tablets, 0.5 mg.; bottles of 100 and 1000.
Composition: Each sublingual tablet contains dihydroergocornine, dihydroergocristine, and dihydroergokryptine methanesulfonates (in equal parts), total 0.5 mg.

HYDERGINE®

SANDOZ

STONY LODGE HOSPITAL

OSSINING-ON-HUDSON, N. Y.

Telephone 914 — WILSON 1-7400

STONY LODGE IS STAFFED AND EQUIPPED TO DO A COMPLETE CLINICAL AND LABORATORY DIAGNOSTIC EVALUATION OF PSYCHIATRIC PROBLEMS.

STONY LODGE maintains an extensive active treatment unit with complete facilities for the organic therapies, including coma-insulin; both regressive and conventional electro-shock therapy. Psychotherapy both analytically oriented and "short-term intensive" is available for those patients where the physical therapies are contra-indicated, but who require hospital care.

Established 1928

CAPACITY 61

Recreational and Occupational Therapy Swimming Pool, Athletic Field, Tennis Court

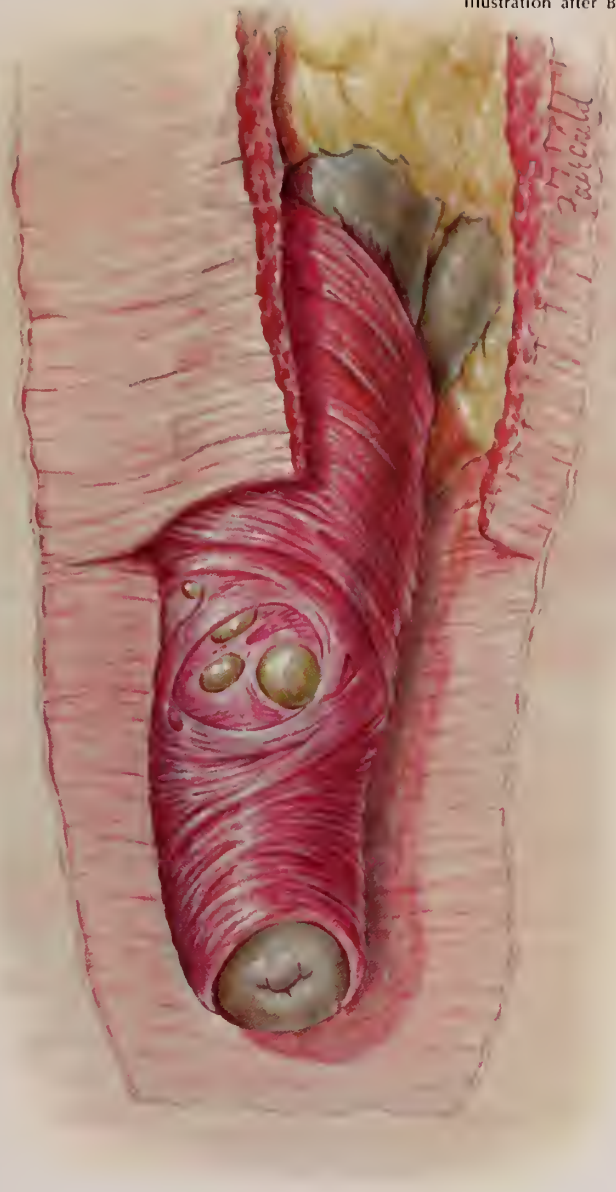
TWENTY LANDSCAPED ACRES — GARDENS — PROMENADES

750 FEET ABOVE SEA LEVEL, OVERLOOKING THE HUDSON RIVER

28 MILES NORTH OF NEW YORK CITY

LUIS G. MURILLO, M.D.
Director

illustration after Boyden



HOW IMPORTANT IS THIS

IN YOUR DIAGNOSES OF SMOOTH MUSCLE SPASM?

©1966 Philips Roxane, Inc.

PERHAPS VERY IMPORTANT

The sphincter of Oddi is made up primarily of smooth muscle fibers. It permits the gall bladder to fill, regulates the flow of bile and pancreatic enzymes and in dysfunction is a primary cause of Biliary Dyskinesia. The sphincter of Oddi is but one of five major foci of smooth muscle spasm where SPACOLIN® (Alverine citrate) acts directly with rapid onset and long duration. No neurotropic side effects because Spacolin is a musculotropic counter-spasmodic unrelated to atropine or atropine-like drugs. Spacolin is not contraindicated in prostatic hypertrophy.

SPACOLIN® (Alverine citrate)

Each tablet contains: Alverine citrate .....120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations. DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort. PRECAUTION: Caution is recommended when using in hypotensive patients. SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

*Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

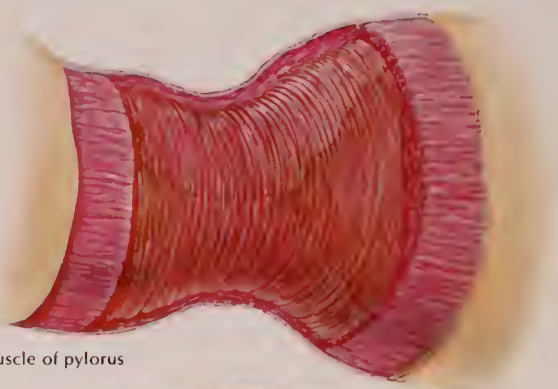
PHILIPS ROXANE LABORATORIES Division of Philips Roxane, Inc., Columbus, Ohio



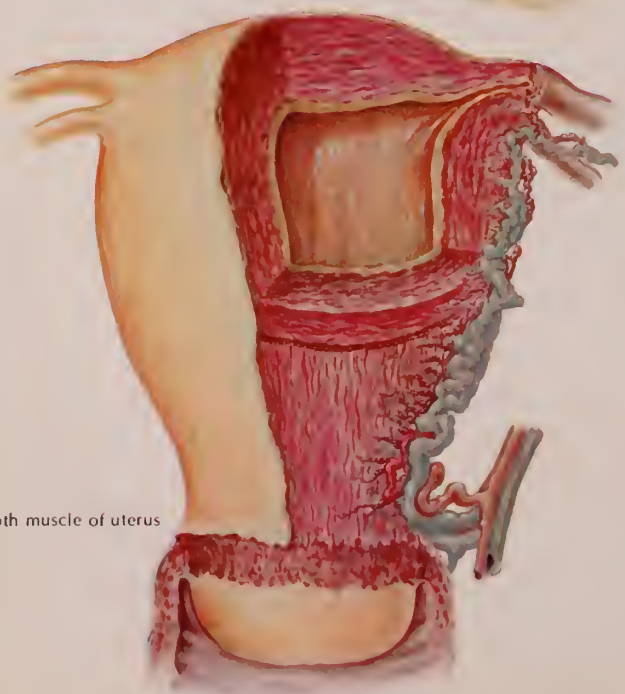
smooth muscle sphincter of Oddi



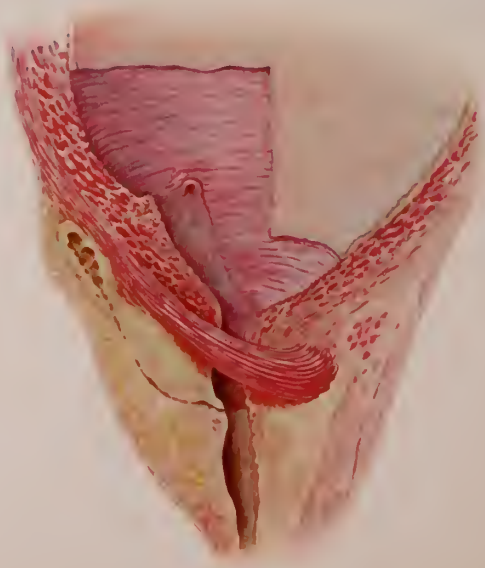
smooth muscle of colon



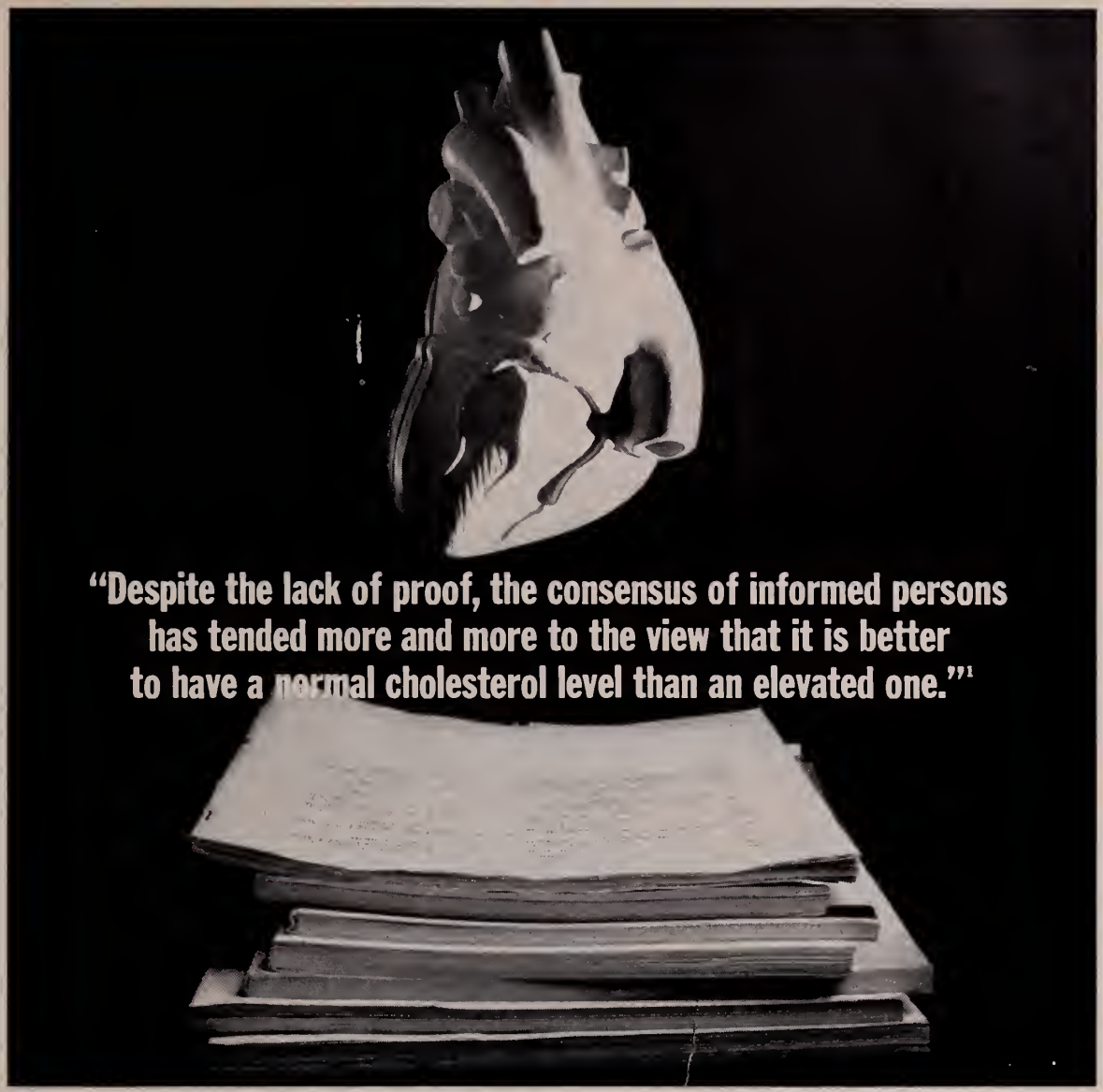
smooth muscle of pylorus



smooth muscle of uterus



smooth muscle of urinary bladder



THE DRUG TO LOWER CHOLESTEROL...

NICALEX®

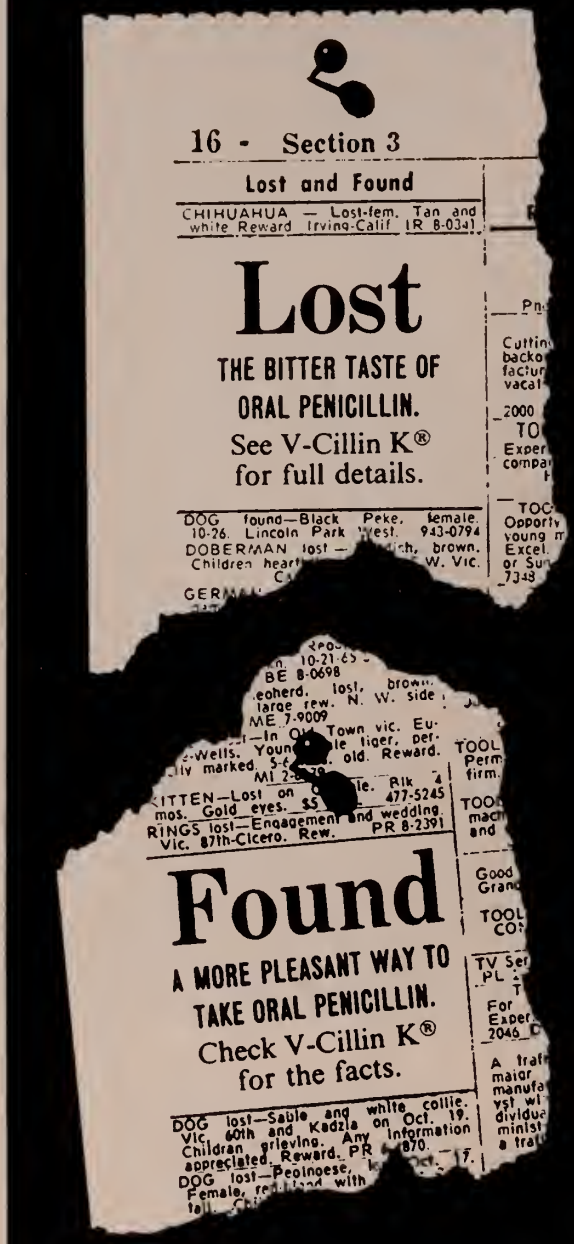
(ALUMINUM NICOTINATE)

- ☐ Reduces cholesterol by 15-30% in most patients[2]
- ☐ Matches nicotinic acid in effective reduction of elevated serum lipids—but with minimized tendency to cause flushing[3]
- ☐ Simpler, more practical than diet[1]

WALKER *Laboratories*

Division of Richardson-Merrell Inc., Mount Vernon, New York 10551

NICALEX Prescribing Information: COMPOSITION: Each tablet contains: Aluminum Nicotinate 625 mg.—a complex consisting of (approx.): Aluminum Hydroxydinicotinate 450 mg. and Nicotinic Acid 155 mg. (Equivalent in activity to Nicotinic Acid 500 mg.) INDICATIONS: The primary indications for NICALEX (Aluminum Nicotinate) are to reduce the serum cholesterol and total lipid levels in hypercholesteremia and hyperlipemia. It may also be useful in reducing xanthomatous tissue cholesterol deposits. PRECAUTIONS AND WARNINGS: Patients with peptic ulcer, liver, or gallbladder disease should be observed closely while taking the medication. Diabetic patients may require adjustment of diet and insulin dosage in the event of decreased tolerance. Patients receiving anti-hypertensive drugs of the adrenal-blocking type should be watched for signs of postural hypotension. Occasional side effects of Nicotinic Acid in large dosage are decreased glucose tolerance (resembling diabetic-type curve) sometimes with glycosuria, temporary activation of peptic ulcer, transient jaundice, and metabolic disturbance of liver function without definite hepatic pathology. These side effects were found to be reversible upon discontinuing nicotinic acid therapy. Certain transitory skin changes have been observed with nicotinic acid therapy. These include: dryness of the skin and keratosis nigricans, particularly in axillae. SIDE EFFECTS: Administration of NICALEX (Aluminum Nicotinate) may produce temporary flushing and pruritus, also mild gastrointestinal distress, but these reactions are transient and apparently not serious. DOSAGE: The adult dose is 2 to 4 tablets t.i.d. with meals. HOW SUPPLIED: In bottles of 100 and 1000. CAUTION: Federal law prohibits dispensing without prescription. REFERENCES: 1. Parsons, W.B., Jr., Mayo Clin. Proc., 40:822, 1965. 2. Goldsmith, G.A., Amer. J. Dig. Dis., 9:651, 1964. 3. Boyle, E., Jr., J. Amer. Geriat. Soc., 10:822, 1962. U.S. Patent 2,970,082



Patients won't complain about bitter penicillin taste when you specify V-Cillin K. Here's why: It has a special coating, only one and a half *thousandths* of an inch thick. Because it is designed to dissolve after approximately six seconds, this barrier to bitterness remains on the tablet as it slides past the tongue. When the tablet reaches the stomach, however, the coating has dissolved, and the penicillin is ready for immediate absorption into the bloodstream.
Result? The proved efficacy of potassium penicillin V without the penalty of bitter taste.

Indications: V-Cillin K is an antibiotic useful in the treatment of streptococcus, pneumococcus, and gonococcus infections and infections caused by sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

Lilly

V-Cillin K®
Potassium Phenoxymethyl Penicillin

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana.
600050

EDITORIALS

But Especially This Year

Every year in this month and in this space, we urge you to come to Atlantic City for the Annual Meeting of your Medical Society. We tell you that this is the parliament of New Jersey medicine, and so it is. We tell you that here is a chance to meet old colleagues and old classmates. And so it is. We remind you that Atlantic City is the playground of the world and that people travel thousands of miles to get there; and here it is in our own backyard. We write of salt water taffy (which has no salt water in it, so hypertensives may eat it with pleasure), shore dinners, balmy ocean breezes, and the original (though much copied) boardwalk. We remind you that in a few days here you can get a compact postgraduate course, a chance to look at the exhibits and find out what's new, an opportunity to see our organizational wheels go round, and to take part in turning them.

This was true every year. But something new has been added. Now, 1966, is the bicentennial anniversary, and we'll never have another one. So it's literally unique.

We are the oldest medical organization in America (North, South, or Central). In our great and glittering country, very few organizations can claim a 200-year history. So, we have a magnificent heritage and we propose to tell the world about it. Naturally, this Annual Meeting has to be something special. And it is. Our committees have always culled the proffered papers and exhibits and selected the best. They do it every year. But 1966 is special. It has to be. No one was invited to give a paper unless he was a top authority in his field. Proposed exhibits – commercial as well as medical—were double-screened. Everything in Atlantic City during the week of May 15 is worthy of this remarkable occasion.

We trust you get the message.

The Duty To Become Involved

"A certain man fell among thieves which wounded him, leaving him half dead. A priest saw him and passed by on the other side. Likewise a Levite looked upon him and passed by on the other side. But a certain Samaritan, as he journeyed, saw him and had compassion on him, and bound up his wounds and brought him to an inn and took care of him. . . ." (Luke, 10:30)

And so it happened that the word for an inhabitant of Samaria, a western Aramaic land, became a synonym for the involved and compassionate passer-by.

We live in so tightly packed a society that we may conclude that only non-involvement will assure privacy. In a rural area, you may know the size of the mortgage on the next farm—several miles away. But in a city or suburban apartment house, you may not want to know even the name of the family on the floor below, let alone his business or personal problems.

During the last few years, there has been mounting public interest (though not mounting indignation) at the cult of non-involvement; a feeling that you must not stick your nose in other people's business. Any citizen may find himself faced with a situation where he must decide at once whether to risk looking like Don Quixote in order to play Sir Galahad. In France the law reads that "a person who abstains from giving assistance to someone in danger, when he can do this without risk for himself," is subject to from 3 to 60 months in prison. But in the United States there is no such legislation. This cannot be blamed on any passion for privacy peculiar to the English-speaking peoples, since in the Australian State of Victoria, harsh penalties are imposed upon "any person whose motor car on a highway has caused an accident and who fails to stop and render assistance."

The problem involves physicians in three areas: First, the doctor's legal and ethical duty to render assistance when he sees someone in need of it. Second, the problem of protecting other people from contagious disease or viol-

ence by using medical knowledge acquired in confidence. And the third, the barrier to good medical care erected by indifferent or fanatical relatives.

The AMA's canons of ethics urge the physician to render service in an emergency, but assure him that "a physician may choose whom he will serve."[1] And there is no legal objection in our country to refusing to be a Samaritan. In New South Wales (the Australian State where Sydney is), the law[2] brands as "infamous" the conduct of a medical practitioner "who fails to attend a person when he has reasonable cause to believe that the person is in urgent need of medical attention."

In New Jersey, at least, the physician who renders emergency medical service is protected against malpractice litigation resulting from it. But all this is only the Law—important enough, to be sure, but not quite the same as a moral or ethical obligation.[3]

Ethics and law are firmer when it comes to protecting an innocent victim from contagion or violence by revealing a professional confidence. Section 9 of the AMA's ethical code permits a physician to reveal confidence "when it becomes necessary to do so to protect the welfare of the individual or the community." And if a paranoid patient tells his doctor that he is planning a murder, there is certainly an ethical and legal obligation to report this to law-enforcement officials. Bullet-wounds, contagious diseases, and epilepsy are all reportable under New Jersey law. So here there is legal as well as moral sanction for the practitioner's involvement.

If the religious fanaticism or indifference of a parent refuses permission for a life-saving procedure, there is legal provision for making the child a ward of the State; and recent legislation protects doctors who make reports on battered child cases.

The bell tolls for all of us. Other people's business is often our business. The rights and dignities of the least of us cannot be invaded without lessening our own rights and dignities. This truth should be binding on all people; and for the physician, the responsibility of involvement is even heavier.

There are, of course, dangers in becoming involved: fear of injury, loss of time, inconvenience, and a general reluctance to be branded as an officious busybody. But in a broad sense, we *are* our brothers' keepers . . . a question that, we had assumed, was settled several millenia ago.

Jet-Propelled Smallpox

Universal vaccination in the USA had, we assumed, eliminated smallpox. But in the last decade, 100 cases have been diagnosed in this country. It is believed that this miniature but deadly epidemic started with eight cases in persons who acquired their smallpox abroad* and imported it into our nation. Nearly all of the other 92 cases resulted from exposure to these eight.

Current studies indicate that the level of immunity against smallpox may be dangerously low in these United States. We have felt so secure behind our vaccination barrier that we have allowed immunity to lapse, or reach absurdly minimal levels. While all Americans ought to maintain a high immunity level, the need is especially acute among those who work closely among others—physicians, nurses, and hospital personnel of all sorts.

Jet-propelled aircraft can now reach us in a few hours from the most disease-ridden parts of the world. The public health implications are obvious, potentially ominous, and easily shrugged off.

1. Section 5 of the AMA *Principles of Medical Ethics*.

2. The 1963 revision of the Medical Practitioners' Act of New South Wales.

3. The Sentry Insurance Company at 200 Strong Avenue, Stevens Point, Wisconsin, has published a booklet, "The Good Samaritan and the Bad," which reviews many aspects of this problem—and is yours gratis if you will write and ask for it.

* In the October 1965 issue of *Hospitals* (Journal of the American Hospital Association) is an interesting, fact-filled, and usable review of this problem.

BICENTENNIAL CONVENTION

The Medical Society of New Jersey

Saturday-Wednesday
May 14 to 18, 1966

Haddon Hall
Atlantic City

Registration

Saturday and Sunday, May 14 and 15, from 10:00 a.m. to 4:30 p.m.
Monday and Tuesday, May 16 and 17, from 9:00 a.m. to 4:30 p.m.
Wednesday, May 18, from 9:00 a.m. to 3:00 p.m.

Scientific Program

Scientific sessions all day Monday, from 9:30 a.m. to 4:15 p.m.

Bicentennial Scientific Session on Tuesday, from 9:30 a.m. to 11:45 p.m.

Exhibits

History of Medicine—Sunday, May 15, from 12:00 noon to 5:00 p.m.
Monday and Tuesday, May 16 and 17, from 9:00 a.m. to 5:00 p.m.

Special Informational—Sunday, May 15, from 12:00 noon to 5:00 p.m.
Monday and Tuesday, May 16 and 17, from 9:00 a.m. to 5:00 p.m.

Technical—Sunday, May 15, from 12:00 noon to 5:00 p.m.
Monday and Tuesday, May 16 and 17, from 9:00 a.m. to 5:00 p.m.

Reference Committees

Sunday morning, May 15, starting at 10:45 a.m.

House of Delegates

First session—Saturday, May 14, at 4:00 p.m.
Second session—Sunday, May 15, at 2:00 p.m. (election session).
Third session—Wednesday, May 18, at 9:30 a.m.

General Session on Medicare

Sunday afternoon, May 15, at 3:00 p.m. Noted speakers will discuss "What You Should Know About Medicare" from the viewpoint of (1) the Social Security Administration, (2) the Department of Health, Education, and Welfare, and (3) The Carrier (P. L. 89-97).

Bicentennial General Assembly

Tuesday afternoon, May 17, at 2:30 p.m. Participating will be the Governor of New Jersey and leading spokesmen of Medicine.

Golden Merit Award

Saturday afternoon, May 14, at 2:00 p.m. Honored will be those members of MSNJ who have held the degree of Doctor of Medicine for fifty years.

Medical-Surgical Plan

Saturday afternoon, May 13, about 4:15, open discussion on Medical-Surgical Plan will follow first session of the House of Delegates (4:00 p.m.).

Reception for President-Elect

Sunday, May 15, at 6:00 p.m. All members, official guests, and their wives, and Auxiliary members are cordially invited to attend a reception honoring Dr. Joseph R. Jehl. Admission by badge.

Exhibitors' Buffet-Dinner

Monday evening, May 16, at 6:00 p.m. Reception and buffet-dinner honoring annual meeting exhibitors. Tickets will be available at the Registration Desk. $5 per person.

Bicentennial Reception

Tuesday evening, May 17, at 5:30 p.m. The Atlantic City Convention Bureau cordially invites all members, official guests, and their wives, and members of the Woman's Auxiliary to attend a reception in honor of the Society's Bicentennial Anniversary. Admission by badge.

Bicentennial Luncheon

Tuesday, May 17, at 12:30 p.m. Tickets will be available at the Registration Desk. $4 per person.

Bicentennial Dinner-Dance

Tuesday evening, May 17, at 7:00 p.m. Tickets will be available at the Registration Desk. $10 per person.

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Daily Schedule

Saturday-Wednesday
May 14 to 18, 1966

Chalfonte-Haddon Hall
Atlantic City

Friday / May 13, 1966

5:00 p.m.—Board of Trustees

Saturday / May 14, 1966

10:00 a.m.—Registration opens

2:00 p.m.—Golden Merit Award Ceremony

followed by

Reception for Award Recipients and their immediate families

4:00 p.m.—House of Delegates

followed by

Open discussion on the Medical-Surgical Plan of New Jersey

5:30 p.m.—Hudson County Reception honoring President John J. Bedrick, M.D.
(by invitation only)

5:30 p.m.—Essex County Reception
(by invitation only)

8:00 p.m.—Nominating Committee

Sunday / May 15, 1966

10:45 a.m.—Reference Committees

12:00 noon—Exhibits open

2:00 p.m.—House of Delegates
(election)

3:00 p.m.—General Session on Medicare

6:00 p.m.—Reception honoring President-elect Joseph R. Jehl, M.D.
All members of MSNJ, official guests, and their wives, and members of the Woman's Auxiliary are cordially invited to attend.
(Admission by badge.)

7:30 p.m.—Passaic County Dinner honoring President-elect Joseph R. Jehl, M.D.
(by invitation only)

Monday / May 16, 1966

9:30 a.m.—Scientific Sessions:
(1) Allergy, Dermatology, Pediatrics
(2) Clinical Pathology, Medicine, Rheumatism
(3) Gastroenterology and Proctology, Metabolism, Surgery
(4) Ophthalmology, Otolaryngology

12:30 p.m.—Luncheons:
(1) Radiological Society of New Jersey
(2) New Jersey Association of School Physicians
(3) New Jersey Chapter, American College of Chest Physicians

2:00 p.m.—Scientific Sessions:
(1) Anesthesiology, Obstetrics and Gynecology
(2) Cardiovascular Diseases, Chest Diseases, General Practice
(3) Psychiatry and Neurology
(4) Radiology, Urology

6:00 p.m.—Exhibitors' Reception and Buffet-Dinner
All members, official guests, and their wives, and members of the Woman's Auxiliary are cordially invited to attend.
($5.00 per person)

Tuesday / May 17, 1966

Bicentennial Day

9:30 a.m.—Scientific Program

12:30 p.m.—Luncheon
All members, official guests, and their wives, and members of the Woman's Auxiliary are cordially invited to attend.
($4.00 per person)

2:30 p.m.—General Assembly on History and Medicine

5:00 p.m.—Exhibits close

5:30 p.m.—Reception sponsored by the Atlantic City Convention Bureau
All members, official guests, and their wives, and members of the Woman's Auxiliary are cordially invited to attend.
(Admission by badge.)

7:00 p.m.—Dinner-Dance honoring President John J. Bedrick, M.D.
All members, official guests, and their wives, and members of the Woman's Auxiliary are cordially invited to attend.
($10.00 per person)

Wednesday / May 18, 1966

9:30 a.m.—House of Delegates

12:30 p.m.—Luncheon recess for Delegates

1:30 p.m.—House of Delegates
(continued)

3:00 p.m.—Registration closes

4:00 p.m.—Board of Trustees

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Bicentennial General Assembly

Tuesday, 2:30 p.m. May 17, 1966

The Medical Society Of New Jersey — An Historical, Scientific, and Civic Appraisal

A Civic Appraisal

HONORABLE RICHARD J. HUGHES, Governor of New Jersey, Trenton





An Historical Appraisal

MORRIS FISHBEIN, M.D., Professor Emeritus, Department of Medicine, University of Illinois College of Medicine; Medical Author and Editor, Chicago, Ill.

A Scientific Appraisal

JAMES Z. APPEL, M.D., President, American Medical Association, Lancaster, Pa.





Response

JOHN J. BEDRICK, M.D., President

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Reference Committees

Sunday, 10:45 a.m. May 15, 1966

Reference Committee "A"

Reports of the:
- President
- Board of Trustees
- Secretary
- Judicial Council
- Executive Director
- Committee on Credentials

Reference Committee "B"

Reports of the:
- Treasurer
- Committee on Finance and Budget
- Committee on Medical Student Loan Fund
- Committee on Publication

Reference Committee "C"

Reports of the:
- Medical Service Administration
- Medical-Surgical Plan
- Dependents' Medicare Program

Reference Committee "D"

Reports of the:
- Committee on Medical Defense and Insurance
- Committee on Medical Education
- Committee on Medicine and Religion
- Committee on Retirement Plan for Physicians

Reference Committee "E"

Reports of the:
- Council on Legislation
- Council on Public Relations

Reference Committee "F"

Reports of the:
- Council on Medical Services, and its
- Special Committees on:
  - Chronically Ill and the Aging
  - Occupational Health, Rehabilitation, and Workmen's Compensation

Reference Committee "G"

Reports of the:
- Council on Public Health, and its Special Committees on:
  - Air Pollution
  - Cancer Control
  - Child Health
  - Conservation of Hearing and Speech
  - Conservation of Vision
  - Maternal and Infant Welfare
  - Mental Health

Reference Committee "H"

Reports of the:
- Committee on Annual Meeting, and its Subcommittees on:
  - History Exhibits
  - Scientific Program
- Committee on Honorary Membership
- Committee on Disaster Medical Care
- Committee on Nursing Education and Recruitment
- Committee on Traffic Safety
- Advisory Committee to the Women's Auxiliary

Nominations for Emeritus Membership

Reference Committee on Constitution and Bylaws

Amendment to Bylaws

Report of the Committee on Revision of Constitution and Bylaws

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

House of Delegates

Saturday, 4:00 p.m.	May 14, 1966
Sunday, 2:00 p.m.	May 15, 1966
Wednesday, 10:00 a.m.	May 18, 1966

Sessions

Saturday Afternoon / May 14 / 4:00 p.m.

First Session

Invocation
Rabbi Morris Tosk
Temple Beth Am, Bayonne

Call to order

Organization of House of Delegates

Transactions of 1965 Annual Meeting

Transactions of 1965 Special Meeting

Introduction of guests and delegates from other state medical societies

Annual and supplemental reports

Proposed amendments to the Constitution and Bylaws

Resolutions

Election of Honorary Members

New business

Announcements

Sunday Afternoon / May 15 / 2:00 p.m.

Second Session

Report of Nominating Committee

Election

Wednesday Morning / May 18 / 10:00 a.m.

Third Session

Reports of Reference Committees

Unfinished business

Bestowal of Honorary Memberships

Address of the President

Installation of the Incoming President

Inaugural address

Adjournment

(Luncheon recess from 12:30 p.m.-1:30 p.m.)

President—John J. Bedrick, M.D., Bayonne
Secretary—Marcus H. Greifinger, M.D., Newark
Speaker—Jesse McCall, M.D.
Parliamentarian—Robert M. Backes, Trenton

OFFICES TO BE FILLED BY ELECTION — 1966 ANNUAL MEETING

Office	Term	From	To	Incumbent and County
President-Elect	1 year	May 1966	May 1967	Joseph R. Jehl Passaic
1st Vice-President	1 year	May 1966	May 1967	Louis K. Collins Gloucester
2nd Vice-President	1 year	May 1966	May 1967	John F. Kustrup Mercer
Secretary	1 year	May 1966	May 1967	Marcus H. Greifinger Essex
Treasurer	1 year	May 1966	May 1967	Daniel F. Featherston Monmouth
Trustees:				
2nd District	3 years	May 1966	May 1969	*-Joseph P. Donnelly Hudson
3rd District	3 years	May 1966	May 1969	George E. Barbour Somerset
3rd District	3 years	May 1966	May 1969	Samuel J. Lloyd Mercer
4th District	3 years	May 1966	May 1969	Frank J. Hughes Camden

(*-Third full term expiring; ineligible for re-election).

Office	Term	From	To	Incumbent and County
Judicial Councilors:				
1st District	3 years	May 1966	May 1969	Thomas S. P. Fitch Union
4th District	3 years	May 1966	May 1969	E. Vernon Davis Burlington
AMA Delegates:				
	2 years	Jan. 1967	Dec. 1968	C. Byron Blaisdell Monmouth
	2 years	Jan. 1967	Dec. 1968	Marcus H. Greifinger Essex
	2 years	Jan. 1967	Dec. 1968	Frank J. Hughes Camden
	2 years	Jan. 1967	Dec. 1968	Luke A. Mulligan Bergen
AMA Alternate Delegates:				
	2 years	Jan. 1967	Dec. 1968	F. Clyde Bowers Morris
	2 years	Jan. 1967	Dec. 1968	Matthew E. Boylan Hudson
	2 years	Jan. 1967	Dec. 1968	Jerome G. Kaufman Essex
	2 years	Jan. 1967	Dec. 1968	John F. Kustrup Mercer
Delegates and Alternate Delegates to Other States:				
New York:				
Delegate	1 year	1967 Annual Meeting		Joseph P. Donnelly Hudson
Alternate	1 year	1967 Annual Meeting		Paul H. Steel Atlantic
Connecticut:				
Delegate	1 year	1967 Annual Meeting		Lloyd A. Hamilton Hunterdon
Alternate	1 year	1967 Annual Meeting		Josiah C. McCracken Atlantic
Administrative Councils:				
Legislation:				
5th District	3 years	May 1966	May 1969	John S. Madara Salem
6th Member	3 years	May 1966	May 1969	Winton H. Johnson Bergen
Medical Services:				
5th District	3 years	May 1966	May 1969	Charles B. Norton, Jr. Salem
6th Member	3 years	May 1966	May 1969	I. Edward Ornaf Camden
Public Health:				
5th District	3 years	May 1966	May 1969	Carl J. Records Cape May
6th Member	3 years	May 1966	May 1969	John P. Coughlin Hudson
Public Relations:				
2nd District	3 years	May 1966	May 1969	Francis I. Tomlins Bergen
5th District	3 years	May 1966	May 1969	Josiah C. McCracken Atlantic
Standing Committees:				
Annual Meeting:	3 years	May 1966	May 1969	*Robert E. Verdon Bergen
Finance and Budget: (member of 1966 House of Delegates)				
	3 years	May 1966	May 1969	Theodore K. Graham Passaic
Medical Defense and Insurance:				
	3 years	May 1966	May 1969	Ernest C. Hillman, Jr. Essex
Medical Education:				
	3 years	May 1966	May 1969	Louis F. Albright Monmouth
Publication:				
	3 years	May 1966	May 1969	George B. Sharbaugh Mercer
Woman's Auxiliary Advisory:				
	3 years	May 1966	May 1969	George O. Rowohlt Bergen

(*Appointed by Board of Trustees for ½ year unexpired term of Herschel S. Murphy, M.D., deceased.)

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General Session on Medicare

Sunday, 3:00 p.m. May 15, 1966

Introduction
JOHN J. BEDRICK, M.D., President

Presiding
ERNEST B. HOWARD, M.D.
Assistant Executive Vice-President
American Medical Association



Ernest B. Howard, M.D.
Chicago, Ill.



Arthur E. Hess
Baltimore, Md.



John W. Cashman, M.D.
Washington, D. C.



William C. White, Jr.
Newark

What You Should Know About Medicare —

From the Viewpoint of the Social Security Administration

ARTHUR E. HESS, Director, Bureau of Health Insurance, Social Security Administration, Department of Health, Education, and Welfare, Baltimore, Md.

From the Viewpoint of the Public Health Service

JOHN W. CASHMAN, M.D., Chief, Division of Medical Care Administration, Public Health Service, U. S. Department of Health, Education, and Welfare, Washington, D. C.

From the Viewpoint of The Carrier (P. L. 89-97)

WILLIAM C. WHITE, Jr., The Prudential Insurance Co. of America, Newark, N. J.

EXHIBITS: YOUR THREE-WAY TREAT!

One of the colorful aspects of any medical convention is the array of exhibits. This year, your Society provides three classes of exhibits: Informational, Historic, and Technical. Take the time to inspect all of them — not just a looksee and not a once-over-lightly scanning, either. But a real, indepth study. You'll be surprised how much you can learn.

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SCIENTIFIC PROGRAM

Monday, May 16, 1966
Regular Joint Sessions

Tuesday, May 17, 1966
Bicentennial Session

Scientific Section Officers

Allergy
CHAIRMAN—Maclyn Cagan, M.D., Rahway
SECRETARY—Roslyn Barbash, M.D., Teaneck

Anesthesiology
CHAIRMAN—Stephen H. Mazur, M.D., Short Hills
SECRETARY—Francis G. Casey, Jr., M.D., North Plainfield

Cardiovascular Diseases
CHAIRMAN—Marvin C. Becker, M.D., Millburn
SECRETARY—Gilbert E. Levinson, M.D., Jersey City

Chest Diseases
CHAIRMAN—Mervin G. Olinger, M.D., Verona
SECRETARY—Alfred Yager, M.D., North Bergen

Clinical Pathology
CHAIRMAN—S. Raymond Gambino, M.D., Englewood
SECRETARY—Jacques B. Wallach, M.D., Westfield

Dermatology
CHAIRMAN—Sam C. Atkinson, M.D., Morristown
SECRETARY—Hugh McCulloch, Jr., M.D., Plainfield

Gastroenterology and Proctology
CHAIRMAN—Abraham I. Friedman, M.D., Hackensack
SECRETARY—Robert Horowitz, M.D., Jersey City

General Practice
CHAIRMAN—Gustav L. Ibranyi, M.D., Newark
SECRETARY—Victor H. Boogdanian, M.D., New Brunswick

Medicine
CHAIRMAN—Joseph A. Linsk, M.D., Atlantic City
SECRETARY—Milton Cutler, M.D., Atlantic City

Metabolism
CHAIRMAN—Murray D. Shepp, M.D., Trenton
SECRETARY—Henry A. Terwedow, M.D., North Bergen

Obstetrics and Gynecology
CHAIRMAN—Robert E. Sexton, M.D., Point Pleasant
SECRETARY—James L. Breen, M.D., Newark

Ophthalmology
CHAIRMAN—Anthony M. Sellitto, M.D., South Orange
SECRETARY—Oram R. Kline, Jr., M.D., Camden

Otolaryngology
CHAIRMAN—Thomas F. Flynn, Jr., M.D., Woodbury
SECRETARY—August P. Ciell, M.D., Haddonfield

Pediatrics
CHAIRMAN—Robert Forer, M.D., Trenton
SECRETARY—Suzanne A. Widrow, M.D., Hanover

Psychiatry and Neurology
CHAIRMAN—Arnold M. Kallen, M.D., Newark
SECRETARY—Bernard R. Goldberg, M.D., East Orange

Radiology
CHAIRMAN—John W. Marquis, M.D., Chatham
SECRETARY—John R. Helff, M.D., New Brunswick

Rheumatism
CHAIRMAN—Georgia E. Allen, M.D., Haddon Heights
SECRETARY—Peter W. Vanace, M.D., Haddonfield

Surgery
WILLIAM E. PHILIP, M.D., Morristown
SECRETARY—Adolph R. Wichman, M.D., Denville

Urology
CHAIRMAN—Robert L. Lieb, M.D., South Orange
SECRETARY—Anthony R. Fernicola, M.D., Newark

Scientific Sessions

Monday Morning / May 16

Joint Session

Sections on

Allergy
Dermatology
Pediatrics

Presiding

Maclyn Cagan, M.D., Chairman
Section on Allergy

9:30 a.m. / **Election of Section Officers for 1966-1967**

9:45 a.m. / **The Immunologic Basis of Allergic Disease**

ELLIOT F. ELLIS, M.D., Instructor in Pediatrics, University of Florida College of Medicine, Gainesville, Fla.

The antibody thought to be responsible for the immediate type of wheal and flare reactivity (seen in individuals with hay fever and asthma) has very special physico-chemical properties. The most recent data indicate that reaginic antibody does not belong to any one of the four known classes of immunoglobulins but rather may represent still another distinctive molecular species of gamma globulin. The mechanism of the injury produced by the interaction of antigen with reaginic antibody is also of great current interest because it appears to be non-complement dependent.

10:15 a.m. / **Itch Mechanisms**

FRANK E. CORMIA, M.D., Clinical Professor of Dermatology, Cornell University Medical College, New York, N. Y.

A summary is given of some of the mechanisms involved in the development of itching. Then selected diseases associated with itching will be discussed. Finally current methods of therapy will be evaluated.

10:45 a.m. / **Allergic Diseases of the Respiratory Tract**

GEORGE B. LOGAN, M.D., Professor of Pediatrics, Mayo Graduate School of Medicine, University of Minnesota; Consultant in Section of Pediatrics, Mayo Clinic, Rochester, Minn.

The care of children having allergic disease of the respiratory tract leaves much to be desired. Too many parents and physicians are complacent about present management. While no one has a "cure," we can, with the knowledge and the tools we presently have conspicuously improve management. Difficulties encountered in diagnosis, determination of etiology, parent education, hyposensitization, symptomatic therapy, and problems of infection will be discussed. Measures will be suggested for improvement in each area.

11:15 a.m. / **Question and Answer Period**

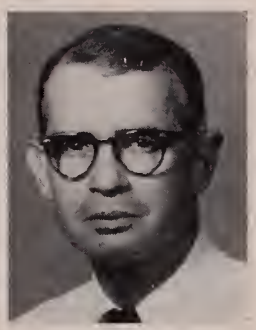
11:45 a.m. / **Visit to Exhibits**



Elliot F. Ellis, M.D.
Gainesville, Fla.



George B. Logan, M.D.
Rochester, Minn.



Elliott F. Osserman, M.D.
New York, N. Y.



Theodore H. Spaet, M.D.
New York, N. Y.



Malcolm M. Hargraves, M.D.
Rochester, Minn.

Joint Session

Sections on

Clinical Pathology
Medicine
Rheumatism

Presiding

S. Raymond Gambino, M.D., Chairman
Section on Clinical Pathology

9:30 a.m. / Election of Section Officers for 1966-1967

9:45 a.m. / Clinical and Biochemical Aspects of Plasma Cell Dyscrasias

ELLIOTT F. OSSERMAN, M.D., Associate Professor of Medicine, Columbia University College of Physicians and Surgeons; Visiting Physician, Francis Delafield Hospital, New York, N. Y.

"Plasma cell dyscrasia" is a general term which encompasses the range of pathologic conditions and biochemical abnormalities considered to represent unbalanced proliferative disorders of the cells which normally synthesize gamma (immuno-) globulins. The extent of the proliferative abnormality in the various plasma cell dyscrasias ranges from apparently autonomous, malignant proliferation (neoplasia) in typical multiple myeloma to apparently benign and stable dyscrasias manifested principally by their associated gamma globulin abnormalities. The plasma cell dyscrasias are characterized by: (a) the proliferation of plasma cells in the absence of an identifiable antigenic stimulus; (b) elaboration of electrophoretically and structurally homogeneous "M-type" (myeloma, macroglobulinemia) gamma globulins and/or excessive quantities of comparably homogeneous polypeptide subunits of these proteins (i.e., Bence Jones proteins, H-chains, etc.); and, (c) commonly, an associated deficiency in the synthesis of normal immunoglobulins.

10:15 a.m. / Disordered Hemostasis

THEODORE H. SPAET, M.D., Head, Department of Hematology, Montefiore Hospital and Medical Center, New York, N. Y.

Congenital blood coagulation disorders are relatively rare, but they receive most of the attention in the literature. Acquired defects are quite common, and their identification can be of considerable clinical value.

The acquired coagulopathies typically present complex patterns of depressed factors. These patterns reflect the pathogenesis of the problem. The clotting factors can be conveniently grouped into those which are vitamin K dependent, those which are made in the liver, and those which are consumed in the course of blood coagulation. Suitable clotting factor assays can thus identify vitamin K deficiency, liver disease, or defibrination, as well as certain other underlying diseases.

The value of these studies includes improved diagnostic accuracy and often important therapeutic information. For example, the administration of vitamin K in the presence of liver disease may actually favor hemorrhagic manifestations.

10:45 a.m. / The Mesenchymal Dyscrasias and Some Ecological Observations

MALCOLM M. HARGRAVES, M.D., Rochester, Minn.

Man is still a biologic creature, and to survive he must continually react with his environment. But today his environment is in a continuous state of flux. Much of this environment change is due to the addition of new and exotic chemical agents as well as to increased contact with the old ones. Not only must he make emotional adjustment to the great social changes involved but he must adjust with adequate immunologic and detoxifying response to each challenge of a new environmental agent with biochemical potentials. Many individuals are reacting adversely to this new environment with resulting acute and chronic illness. Scrupulous investigation of the patient's environment by intensive historical interviews may lead to his rehabilitation by altering his environment.

11:15 a.m. / Question and Answer Period

11:45 a.m. / Visit to Exhibits



Henry Colcher, M.D.
New York, N. Y.



Augustus L. Baker, Jr., M.D.
Dover



Herman Steinberg, M.D.
New York, N. Y.



William F. Mitty, Jr., M.D.
Staten Island, N. Y.

Joint Session

Sections on

Gastroenterology and Proctology Metabolism Surgery

Presiding

William E. Philip, M.D., Chairman
Section on Surgery

9:30 a.m. / Election of Section Officers for 1966-1967

9:45 a.m. / Endocrine Disorders and Peptic Ulcers

HENRY COLCHER, M.D., Assistant Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons; Assistant Attending Physician, Vanderbilt Clinic, Department of Medicine, Columbia-Presbyterian Medical Center, New York, N. Y.

Endocrine disturbances influence gastric secretion and may be associated with gastric and duodenal ulcers. The mechanisms involved are here presented. Particular attention will be given to the role of the pituitary, the adrenal, and the parathyroid glands and the pancreas. The role of gastrin and the responsiveness of the parietal cells to stimuli will be discussed.

10:05 a.m. / Surgery for Peptic Ulcer

AUGUSTUS L. BAKER Jr., M.D., Chairman and Attending, Department of Surgery, Dover General Hospital, Dover.

Although only 15 percent of patients being treated for peptic ulcer will eventually require surgery, there is a wide choice of procedures available to the surgeon. The indications for each are still undergoing some change. This paper reviews the physiologic, anatomic, and historical basis for some of the procedures. Results obtained by several clinics will be compared.

10:25 a.m. / What's New in Peptic Ulcer Therapy

HERMAN STEINBERG, M.D., Assistant Clinical Professor of Medicine, Cornell University Medical College; Assistant Attending Physician, Department of Medicine, New York Hospital, New York, N. Y.

This presentation lights up the apparent discrepancies between theoretical considerations and the results actually attained in the treatment of peptic ulcer. An effort to reconcile these apparent discrepancies is developed.

10:45 a.m. / The Indications for Surgery in Duodenal Ulcer and the Operative Procedure of Choice

WILLIAM F. MITTY, Jr., M.D., Assistant Clinical Professor of Surgery, New York University School of Medicine; Director of Surgery, St. Vincent's Hospital, Staten Island, N. Y.

This is a report on the management of 3217 patients with duodenal ulcer over a period of 8 years. These cases were from both St. Vincent's Hospital & Medical Center of the City of New York and St. Vincent's Hospital, Staten Island, New York. Almost a thousand patients underwent a subtotal gastrectomy as the procedure of choice. The indications for surgery will be elaborated. The rationale for a subtotal gastrectomy will be discussed.

11:05 a.m. / Question and Answer Period

11:45 a.m. / Visit to Exhibits



Frederick Harbert, M.D.
Philadelphia, Pa.



Richard C. Troutman, M.D.
New York, N. Y.



Kelvin A. Kasper, M.D.
Philadelphia, Pa.



Jay Jacoby, M.D.
Philadelphia, Pa.

Joint Session

Sections on

Ophthalmology
Otolaryngology



Thorkild W. Andersen, M.D.
Gainesville, Fla.



Otto C. Phillips, M.D.
Pittsburgh, Pa.

Presiding

Anthony M. Sellitto, M.D., Chairman
Section on Ophthalmology

9:30 a.m. / Election of Section Officers for 1966-1967

9:45 a.m. / Para-Orbital Conditions

FREDERICK HARBERT, M.D., Professor and Head, Department of Otolaryngology, The Jefferson Medical College, Philadelphia, Pa.

Diseases and conditions of structures around the orbit which may produce orbital manifestations will be described and illustrated by representative lantern slides. These will include disease of the sinuses, nasopharynx, and skin. For example, fibrous dysplasia, injuries to the orbital walls, sinusitis, benign and malignant tumors will be reviewed.



Bradley E. Smith, M.D.
Miami, Fla.

10:15 a.m. / New Trends in Surgery of the Anterior Segment

RICHARD C. TROUTMAN, M.D., Professor of Ophthalmology, Department of Surgery, State University of New York Downstate Medical Center, Brooklyn, N. Y.; Surgeon Director, Manhattan Eye, Ear and Throat Hospital, New York, N. Y.

During the past decade, there have been many exciting new trends in surgery of the anterior segment, such as, alphachymotrypsin, ophthalmic microsurgery, biosurgery, keratomeulisis, and artificial corneas. These entities will be discussed from the standpoint of their initial promise and their eventual value.

The talk will be illustrated by slides and motion picture films.

10:45 a.m. / Discussion: Ethmofrontal Mucoceles

KELVIN A. KASPER, M.D., Professor of Clinical Otolaryngology, The Jefferson Medical College; Chief of Otolaryngology, Wills Eye Hospital, Philadelphia, Pa.

Ethmofrontal mucoceles will be discussed. A movie will be shown, outlining the operative technic on a living subject and a cadaver.

11:15 a.m. / Question and Answer Period

11:45 a.m. / Visit to Exhibits

Monday Afternoon / May 16

Joint Session

Sections on

Anesthesiology
Obstetrics and Gynecology

Presiding

Stephen H. Mazur, M.D., Chairman
Section on Anesthesiology

2:00 p.m. / Election of Section Officers for 1966-1967

2:15 p.m. / Selection of Anesthesia for Delivery

JAY JACOBY, M.D., Professor and Chairman, Department of Anesthesiology, The Jefferson Medical College, Philadelphia, Pa.

The basic question in anesthesia for delivery is whether it should be regional or general. Then the drug and method of application must be decided. A number of the factors that enter into this decision will be discussed.

2:35 p.m. / Cardiovascular Changes During Anesthesia and Caesarian Section

THORKILD W. ANDERSEN, M.D., Associate Professor of Anesthesiology, University of Florida College of Medicine, Gainesville, Fla.

The circulation in the pregnant and in the non-pregnant patient, by and large, responds to general anesthesia in the same way. Spinal and epidural block, however, more often cause severe hypotension in the pregnant than in the non-pregnant patient. This hypotension is more frequent and more pronounced during spinal than during epidural block. Hypotension during epidural block is more readily corrected by elevation of the legs or administration of pressor amines than hypotension caused by spinal block. Observations made during elective caesarean sections in patients not in labor showed a good correlation between the blood gases and the pH in the newborn and the status of the maternal circulation at the time of delivery.

Synthetic oxytocin given rapidly intravenously following caesarean section caused transient hypotension, tachycardia, increase in cardiac output and decrease in total peripheral resistance. These cardiovascular changes were not seen following slow intravenous infusion.

2:55 p.m. / Complications of Obstetric Anesthesia

OTTO C. PHILLIPS, M.D., Professor of Anesthesiology, University of Pittsburgh School of Medicine; Chief of Anesthesiology, Magee-Women's Hospital, Pittsburgh, Pa.

3:15 p.m. / Resuscitation of the Newborn Infant

BRADLEY E. SMITH, M.D., Assistant Professor of Anesthesiology, University of Miami School of Medicine, Miami, Fla.

The respiratory center of the newborn is more easily depressed both by drugs and anoxia than is the adult respiratory center. The lungs often need assistance in proper expansion in depressed newborn babies. But the interrelations of these factors and the acidosis of prolonged asphyxia (with the adaptation of the cardiovascular system to airbreathing) is less frequently well understood by the clinician.

The cardinal principles of resuscitation are immediate establishment of a patent airway and prompt but gentle expansion and ventilation of the lungs (either through the infant's own efforts or by external means), and continuous evaluation of the newborn condition. The actual technics, equipment, and drugs for these procedures will be discussed.

3:35 p.m. / Question and Answer Period

4:15 p.m. / Visit to Exhibits



Maurice S. Segal, M.D.
Boston, Mass.



Lawrence E. Meltzer, M.D.
Philadelphia, Pa.

Joint Session

Sections on

Cardiovascular Diseases
Chest Diseases
General Practice

Presiding

Marvin C. Becker, M.D., Chairman
Section on Cardiovascular Diseases

12:30 p.m. / Luncheon — New Jersey Chapter, American College of Chest Physicians

Reservations: Alan A. J. Stolow, M.D. 235 Grove Street, Somerville

2:00 p.m. / Election of Section Officers for 1966-1967

2:15 p.m. / The Intensive Care of Pulmonary Insufficiency

MAURICE S. SEGAL, M.D., Clinical Professor of Medicine, Tufts University School of Medicine; Director, Lung Station (Tufts) and Department of Inhalation Therapy, Boston City Hospital, Boston, Mass.

When ventilatory failure occurs, the rapid recognition of the defect and its multiple complicating factors are necessary to provide adequate patient care. The more common acute respiratory failures seen at the Boston City Hospital will be discussed.

The specific therapeutic measures employed to improve respiratory function will be reviewed.

Finally, the complications occurring during management of these critically ill patients will be discussed.

2:45 p.m. / The Intensive Coronary Care Unit in Acute Myocardial Infarction

LAWRENCE E. MELTZER, M.D., Director, Section of Clinical Investigation, Presbyterian University of Pennsylvania Medical Center, Philadelphia, Pa.

Intensive coronary care nursing is a significant new nursing specialty, due largely to the unusual responsibility placed on the nurse as the key member of the coronary care team. This paper presents a unique service to staff concerned with coronary care units. It offers a complete analysis and guide to the nurses' role in each emergency situation which may arise in patients with acute myocardial infarction. The latter half of the presentation is offered as a guide to electrocardiography. The author gives the causes of the various arrhythmias and conduction defects and the diagnostic criteria for identifying each. A typical analysis of arrhythmias is presented.

3:15 p.m. / The Intensive Care of Renal Insufficiency

NORMAN LASKER, M.D., Associate Professor of Medicine, New Jersey College of Medicine, Jersey City.

Renal insufficiency will be discussed in terms of prevention, diagnosis, and treatment. The functional characteristics of the acute and chronically damaged kidney will be stressed as a guide to optimal medical management. The indications, technics, and complications of acute and chronic peritoneal and hemodialysis will be presented, including the present status of chronic dialysis and renal transplantation.

3:45 p.m. / Question and Answer Period

4:15 p.m. / Visit to Exhibits



Norman Lasker, M.D.
Jersey City



Humphry Osmond, M.R.C.S.
Princeton



Ralph A. Straetz
New York, N. Y.



Morton D. Bogdonoff, M.D.
Durham, N. C.

Section on

Psychiatry and Neurology

Presiding

Arnold M. Kallen, M.D., Chairman
Section on Psychiatry and Neurology

2:00 p.m. / Election of Section Officers for 1966-1967

2:15 p.m. / Symposium on The Impact of Social Change on Medical Service and Practice

Honor a Physician — Some Unusual Thoughts Upon the Doctor-Patient Relationship in These Times

HUMPHRY OSMOND, M.R.C.S., D.P.M., Director, Bureau of Research in Neurology and Psychiatry, New Jersey Division of Mental Health and Hospitals, Princeton

The author discusses differences in the expectation of patients and practitioners caused by the very substantial changes in medicine, surgery, and public health during the last 100 years. These changes have, and are bound to have, altered the relationship between doctor and patient, the role of the patient; and thus, have shifted the role of the physician.

Some of the present discontents voiced by both patients and physicians may arise from changes which (although undoubtedly enormously beneficial) were not understood. This may well cause unnecessary distress to everyone concerned. The author suggests how some of this distress might be alleviated, if only by greater understanding of its genesis.

Social Phenomena and the Physician — Effect of Government Upon His Services

PROFESSOR RALPH A. STRAETZ, Department of Government and International Relations and Adjunct Associate Professor Elena Padilla, New York University, New York, N. Y.

The Social Milieu and the Physician— Effect Upon Medical Education and Medical Practice

MORTON D. BOGDONOFF, M.D., Professor of Medicine, Duke University Medical Center, Durham, N. C.

The relationship of the physician to the patient represents a special type of interaction in the community. As the social changes of the community become more extensive, special modifications must take place in the physician-patient relationship. The physician will need newer technics to work successfully within the changing social scene: automated laboratories, computer screening, group clinics, closed-circuit consultations, professional auditing.

3:45 p.m. / Question and Answer Period

4:15 p.m. / Visit to Exhibits

Joint Session

Sections on

Radiology
Urology

Presiding

Robert L. Lieb, M.D., Chairman
Section on Urology

12:30 p.m. / Luncheon — Radiological Society of New Jersey

Reservations: John W. Marquis, M.D. 15 Buxton Road, Chatham

2:00 p.m. / Election of Section Officers for 1966-1967

2:15 p.m. / Symposium on Current Management of Bladder Neoplasms

Newer Techniques for the Identification of Bladder Neoplasms

IRVING M. BUSH, M.D., Chairman, Department of Urology, Cook County Hospital, Chicago, Ill.

In 142 patients examined by ultraviolet cystoscopy following tetracycline administration at New York's Memorial and James Ewing Hospitals, 35 areas of cancer not visible with conventional illumination were detected as a consequence of ultraviolet tetracycline fluorescence. Some 85 per cent of the conventionally visible cancers demonstrated fluorescence. Ultraviolet spectrographic analysis of urinary sediments for tetracycline increased the positive correlation between fluorescence in urinary sediments and histologic evidence of cancer. Experience with blue-violet light induced acridine orange fluorescence in 28 patients indicates a similarity to the experience with ultraviolet tetracycline fluorescence as far as detection of bladder tumors is concerned but suggests a somewhat higher incidence of false positive fluorescence.

Radiation Therapy in the Management of Bladder Neoplasms

LUTHER W. BRADY, Jr., M.D., Associate Professor of Radiology, Director of Radiation Therapy, The Hahnemann Medical College, Philadelphia, Pa.

Cancer of the bladder is a spectrum of disease ranging from the transitional cell papilloma to the highly invasive and aggressive carcinoma. It comprises a significant and increasing proportion of human cancer. The author presents his experience which demonstrates that complications from radiation therapy (as a means of definitive management) are not such that treatment is contra-indicated for this reason alone. Results of well-planned and well-executed radiation therapy, using supervoltage technics, are comparable with (and may compete with) radical surgery in the treatment of invasive carcinoma of the bladder. Experience with combined radiation therapy and surgical excision of bladder cancer will also be presented.

Pelvic Angiography and Pelvic Pertusion in Carcinoma of the Bladder

JOHN J. MURPHY, M.D., Professor of Urology, University of Pennsylvania School of Medicine, Philadelphia, Pa.

Infusion of cytotoxic agents directly into the arterial supply of the urinary bladder has yielded promising results. Stage and grade of the neoplasm are established by bi-manual examination under anesthesia and visualization of the blood supply of the bladder by catheterization of the hypogastric arteries and introduction of radiopaque medium.

3:45 p.m. / Question and Answer Period

4:15 p.m. / Visit to Exhibits



Irving M. Bush, M.D.
Chicago, Ill.



Luther W. Brady, Jr., M.D.
Philadelphia, Pa.



John J. Murphy, M.D.
Philadelphia, Pa.

Tuesday Morning / May 17

Bicentennial Session

9:30 a.m. / Symposium on G. I. Bleeding

Moderator

JOHN J. BEDRICK, M.D., President

The Medical Approach to G. I. Bleeding

HENRY J. TUMEN, M.D., Professor and Chairman, Department of Medicine, Division of Graduate Medicine, University of Pennsylvania School of Medicine, Philadelphia, Pa.

Gastrointestinal bleeding is a constantly recurring challenge. Although categorical statements are often made about the value of certain diagnostic procedures and about the criteria for planning either medical or surgical therapy, it is obvious that the management of patients who have bled calls for individualization, sound judgment, and flexibility of thought. The recognition of the cause of a hemorrhage may be simple, difficult, or impossible. The problem often becomes one of deciding for or against surgical intervention rather than achieving a complete etiologic diagnosis.

The commonest sources of upper gastrointestinal bleeding are: peptic ulcer disease, erosive gastritis, and gastroesophageal varices. The interrelationships between these, however, are sometimes complex. In many cases, the exact cause of a hemorrhage may never be known. This discussion will be focused upon the development of a diagnostic approach to upper gastrointestinal bleeding, brief review of the diagnostic procedures that seem most helpful, certain questions related to the medical management of hemorrhage, and a discussion of the internist's role in the planning of surgical treatment.

The Surgical Approach to G. I. Bleeding, Esophageal Bleeding — Varices, Hiatal Hernia

WILLIAM S. BLAKEMORE, M.D., Professor and Chairman, Department of Surgery, Division of Graduate Medicine, University of Pennsylvania School of Medicine, Philadelphia, Pa.

The patient with portal hypertension who has a bleeding esophageal varix presents a serious problem in management. Deaths from the first such hemorrhage remain as high as 50 per cent. This paper will discuss several diagnostic and differential diagnostic procedures, including splenoportography. Management methods here reviewed include balloon tamponade, pituitrin, gastric cooling, transesophageal ligation, and portal-caval shunt. The indications, contra-indications, and effectiveness of such method are discussed.

Gastric and Duodenal Bleeding — Ulcers, Neoplasms

JOHN L. MADDEN, M.D., Director, Department of Surgery, St. Clare's Hospital; Clinical Professor of Surgery, New York Medical College, Metropolitan Hospital Center, New York, N. Y.

This is a study of the surgical management of a consecutive series of 210 patients who were admitted to the hospital with the complaint of gastrointestinal bleeding secondary to duodenal or gastric ulcer. Patients were classified according to the severity of the bleeding. Various methods of surgical management are described. The paper concludes with an analysis of results obtained.

11:45 a.m. / Visit to Exhibits



Henry J. Tumen, M.D.
Philadelphia, Pa.



William S. Blakemore, M.D.
Philadelphia, Pa.



John L. Madden, M.D.
New York, N. Y.

bicentennial

Technical Exhibits

Sunday, May 15
12:00 noon to 5:00 p.m.

Monday-Tuesday, May 16-17
9:00 a.m. to 5:00 p.m.

In its Bicentennial year, The Medical Society of New Jersey welcomes the exhibitors listed below as participants in this historic convention. We urge all members of MSNJ and their guests—and those of the Woman's Auxiliary and their guests, too, to give these exhibitors every attention and courtesy. They deserve it. Let us show appreciation for the part they have played during these years of progress in medicine.

Abbott Laboratories

Abbott representatives will be on hand to welcome visiting physicians and to give information on Erythrocin, on the latest developments of Abbott's intravenous solutions and equipment, and on other important Abbott specialties.

American Mutual Liability Insurance Co.

Mr. Joseph Britton, Manager of the Professional Liability Insurance Department for New Jersey, wants to answer any questions and to discuss any problems relating to professional liability or professional premises liability coverages.

Astra Pharmaceutical Products, Inc.

Information and descriptive literature will be offered about Xylocaine® (lidocaine) and Citanest® (propitocaine) local and topical anesthetics, and iron preparations Astrafer® (dextriferron) for intravenous use and Jectofer® (iron sorbitex) for intramuscular administration will be available at the Astra booth presided over by our representative, Mr. Arnold G. Everson.

Ayerst Laboratories*

Ayerst Laboratories, distributors for Beecham Research Laboratories, Inc., will feature Penbritin (ampicillin), the new semi-synthetic broad-spectrum penicillin for wide use in major areas of infection. And they will be highlighting Grisactin, Premarin, and Thiosulfil. Our representatives are able and eager to discuss these or other Ayerst products with you.

Baby Services, Inc.

A warm welcome and a red rose await each visitor at the Baby Service booth. This hospitality for over fifteen years has made Baby Service a conversation piece at every meeting. The latest improvement in diaper service for home and hospital will be on display. Ask about our new layette service for hospitals.

E. & W. Blanksteen Agency, Inc

Information and literature are here available about our officially approved plans of disability, major medical, and life insurance.

The Borden Company

The Borden exhibit has a surprise in store for you about Mull-Soy. We will also feature: Borden's hospital ready-to-feed infant formulas—the most complete line available—Bremil, Mull-Soy, Glucose, etc. Methakote, unique water washable antiseptic cream for diaper rash and cradle cap, and other dermatologicals Methatar, Methaphor, and Methaseptic.

Burroughs Wellcome & Co. (U. S. A.) Inc.

Information will be available on our products and the newest developments from the research facilities of Burroughs Wellcome & Co. Of particular interest at this meeting are Actifed Tablets and Syrup for the treatment of allergies, and the I. V. use of Aerosporin Sterile Powder for the treatment of gram-negative infections, including septicemia.

Cameron-Miller Surgical Instruments Co.

Cameron-Miller will feature the new examining light with cold parallel illumination for body cavity examination, the new wall mounted electrosurgical Midget-Tome, the finest electrically lighted instruments, and the coagulating biopsy forceps. Help us celebrate our 50th year and see why it is better to see than look.

Ciba Pharmaceutical Company

The Coca-Cola Company

Ice-cold Coca-Cola will be served through the courtesy and cooperation of the Coca-Cola Bottling Company of South Jersey and The Coca-Cola Company.

Cypress Pools by the Beach Shop

Dome Chemicals, Inc.

Eastern School for Physicians' Aides

Licensed by the University of the State of New York (Education Department), Eastern School for Physicians' Aides, New York City, is engaged in the training of medical assistants, medical secretaries, medical laboratory technologists, and x-ray technicians. The programs are planned, lectured, and supervised by physicians, who put emphasis on the practical skills demanded by the medical profession. This training enables our graduates to gain the "experience factor" much faster and fill the vacancies of hospitals and doctors' offices with a minimum of orientation and supervision. Of particular interest to The Medical Society of New Jersey is that a large portion of our student body is from New Jersey. Our free placement service will help fill your personnel vacancies.

* Ayerst Laboratories will have two exhibits.

Eaton Laboratories

Since 1939, Eaton Laboratories has pioneered in the development of the nitrofurans, many of which have been available as legend drugs to the profession. Basic and clinical research is continuing on these as well as other classes of compounds. In addition, Eaton Laboratories offers a variety of research and educational services for all phases of medicine. Our medical service representatives welcome the opportunity to furnish you with complete information covering these services to you and the nitrofurans.

Thomas A. Edison Industries

Edison Voicewriter will show a complete line of business recording equipment designed to speed handling of medical paper work. Highlights: Edison Voicewriter executive models . . . for individual use by the doctor in his office and at home. Edison Escort . . . battery-operated portable dictating instrument. Envoy Compact . . . portable magnetic recorder. Televoice . . . phone network dictating systems for accurate, complete medical records in the hospital.

Encyclopaedia Britannica, Inc.

Encyclopaedia Britannica welcomes delegates to the Bicentennial Anniversary Meeting of The Medical Society of New Jersey and invites them to examine the great new edition of Britannica. Official delegates may now purchase this magnificent set at an offer only available at our convention exhibits.

Endo Laboratories, Inc.

Endo Laboratories will present the latest clinical information relating to our products, Coumadin® (Sodium Warfarin), Numorphan® (Oxymorphone) HCL, Percodan®, Percodan®-Demi, Hycomine®, Hycomin® -Compound, Hycodan®, Valpin® (Anisotropine Methylbromide), Valpin®-PB (Anisotropine Methylbromide with Phenobarbital).

C. B. Fleet Company, Inc.

C. B. Fleet Co., Inc. will feature Fleet Enema, the disposable enemas of choice for hospital and home use. We are also presenting Provimalt®, a unique high protein-vitamin-mineral formulation with a 10-year history of clinical testing and patient acceptability. Also featured will be Phospho-Soda and Fleet Theophylline Rectal Unit. Visit our representatives at booth #11 for complete product information.

Geigy Pharmaceuticals

The Geigy exhibit features important new therapeutic developments in the management of cardiovascular disease as well as current concepts in the control of inflammation, hypertension and edema, depression, obesity, and other disorders, which may be discussed with representatives in attendance.

Great Books of the Western World

The greatest writing in 3,000 years of Western civilization, 74 authors and 443 works in 25,000,000 words in the Great Books of the Western World featuring the master key to the Great Books, the Syntopicon. The Unique Syntopicon is the idea index—your key to the Great Books.

Health Insurance Council

Hospital Service Plan of New Jersey

Hospital Service Plan of New Jersey, the nation's pioneer Blue Cross Plan, provides more than 2.8 million persons with the finest in prepaid hospital care protection. With 240 contracting hospitals in New Jersey and adjacent states, and a link to 6,000 other hospitals across the nation through the unique Inter-Plan Service Benefit Bank, Blue Cross makes available comprehensive service benefits for subscribers and their dependents.

Investors Diversified Services, Inc.

Distributed will be the following items not pertinent to our products: four mutual funds, accumulation plans, life insurance, and pension profit-sharing plans.

Kessler Associates, Inc.

Kessler Associates, Inc. presents a comprehensive display of rehabilitation equipment and self-help devices. The special needs of the disabled or geriatric patient are featured. A unique combination of services for the amputee, hemiplegic, paraplegic, or other severely disabled, application of featured items for home care for independent living and appliances that provide independence will be explained by certified personnel.

Lamond Products, Inc.

The Lamond Products — Dermatological Laboratories will introduce our newest product—Neo-Bur-Zin Emulsion — Burow's Emulsion Modified without Lanolin . . . a companion product to the well established Bur-Zin. We will also exhibit Aquol Bath Oil, a significant advance in bath oils. Our representatives will be glad to discuss Bur-Zin, Dermasul—Dermasorcin — Dermastringe, Bur-Cort, Bentical Shake Lotion, Sebana Shampoo—Sebanator Shampoo, Lamotane and Sunprotectol.

Lederle Laboratories

Lederle Laboratories is proud to support the Bicentennial Anniversary Meeting of The Medical Society of New Jersey. As one of the leaders in medical research and quality controlled production, we present Declomycin® V, Aristocort®, and others applicable to your practice.

David and Charles Levinson

David and Charles Levinson, Medical Specialties, present the Medco-Sonlator Mark V and Twin, unique diagnostic-therapeutic products in physical therapy. Also on exhibit will be the Achilleometer, for definitive diagnosis of thyroid conditions. It needs no E.K.G. and has an expanded scale, making for easy, exact reading. The portable Minalator for prescription rental and the Marcontrol, an automatic accessory for resistant low back problems, will also be shown.

Eli Lilly and Company

Our sales representatives in attendance welcome your questions about Lilly products. You may be particularly interested in discussing Keflin® Sodium Cephalothin or C-Quens™ Sequential folder, containing fifteen 80-mcg. tablets of mestranol plus five tablets each combining 80 mcg. mestranol and 2 mg. chlormadinone acetate.

3M Business Products Sales, Inc.

McNeil Laboratories, Inc.

Mr. Paul Lange will be in charge of the McNeil booth, and featured will be Butisol Sodium® (sodium butabarbital), Parafon Forte® and Tylenol® (acetaminophen).

Mead Johnson Laboratories

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Medical-Surgical Plan of New Jersey

The Medical-Surgical Plan of New Jersey booth will feature information on complementary coverage for Medicare, as well as assisting members of the profession on problems involving the Plan's policies, procedures, and payments in other areas. Members of the Society are cordially invited to visit the booth and familiarize themselves with details of the New Jersey "Blue Cross and Blue Shield 65" Medicare complementary program.

Medi-Kal Physicians and Hospital Supply Co.

Medi-Kal will exhibit this year the very latest in physicians' examining room furniture. Our office planning consultant will be in attendance during the entire meeting. Your inquiries will be welcomed.

Merck Sharp & Dohme

The Merck Sharp & Dohme exhibit has been designed to supplement the physicians' therapeutic armamentarium. Technically trained personnel will be present to discuss the scope and variety of services offered.

Milex Products

Latest technics in pelvic cancer screening will be on display. Office and operative gynecologic methods will be discussed. Additions to the Milex patient sex educational program will be available.

Olympus Corporation of America

Olympus Gastro Cameras are the world's first precision intragastric cameras for color photography of stomach wall conditions. Model GT-V features high resolution lens, movable camera tip for total photographic coverage. Model GTF includes integral fiberscope for observation as well as photography. Both have long-life built-in lamps and are supplied with a complete system of accessories.

Organon Inc.

Organon representatives invite your inquiries about Accelerase® which, in a capsule, delivers pancreatic enzymes, bile salts and cellulase to the right place at the right time for maximum efficacy. Accelerase-PB® adds belladonna alkaloids and phenobarbital to the basic Accelerase® formula, and is utilized to provide symptomatic control of hypermotility and involuntary spasm of functional gastrointestinal disturbances. Hexadrol® (dexamethasone) in its new 1.5 mg. once-a-day dosage is also featured.

Ortho Pharmaceutical Corporation

Parke, Davis & Co.

Medical service members of our staff will be in attendance to discuss important Parke-Davis specialties which will be on display.

Pfizer Laboratories

Vistaril (hydroxyzine HCl) calms and relaxes tense, apprehensive patients, but it does not put them to sleep. Children and adults come to the operating room in a quiet and cooperative state. Induction is usually smoother. Adjunctive use of Vistaril permits significant reductions in meperidine or barbiturate dosage. The danger of respiratory and circulatory depression is kept to a minimum. Vistaril adds to the patient's comfort after surgery. Administered preoperatively, it substantially reduces the incidence of postanesthetic excitement, nausea, and vomiting.

The Purdue Frederick Company

Otalgine Drops, an antibiotic, antifungal, anti-inflammatory surfactant, are clinically effective in treating acute and chronic otitis externa and adjunctive acute and chronic otitis media and cleansing of post mastoidectomy cavities due to susceptible organisms. Full information on Senokot Tablets, Granules, Syrup, and Suppositories will also be featured.

Puritan Compressed Gas Corporation

Puritan portable aerosol therapy units which deliver high, heated, humidity and medication will be demonstrated. Also displayed will be the now famous Bennett portable, electric, IPPB unit with Monitoring Spirometer and Cascade Humidifier will be displayed.

See these and other Puritan/Bennett Inhalation Therapy Units.

A. H. Robins Company, Inc.

Robins representatives will be happy for the opportunity to discuss products of interest to you.

Roche Laboratories

Continuing Roche research has produced outstanding contributions to medicine since 1909. The personnel at the exhibit welcome your comments, questions, or suggestions about our products and services.

J. B. Roerig & Company

Representatives of J. B. Roerig & Company will be glad to supply you with complete information concerning our products, which are available to the medical profession. Please feel free to request answers to any questions you may have.

Sandoz Pharmaceuticals

Sandoz Pharmaceuticals will feature Mellaril, Sansert, Cafergot P-B, Fiorinal, and Fiorinal with codeine. Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company

New Saunders books of clinical interest published since last year's meeting include: Ingelfinger, Relman and Finland: **Controversy in Internal Medicine;** Felson et al: **Principles of Chest Roentgenology;**

Friedberg: **Diseases of the Heart**; Lamb: **EKG**; Bockus: **Gastroenterology, Vol. III**; Schaffer: **Diseases of the Newborn**; Nealon: **Management of the Patient with Cancer**; Gellis and Kagan: **Pediatric Current Therapy**; Greenhill: **Obstetrics**; and Conn: **Current Therapy 1966**.

Schering Corporation

Schering Corporation representatives will be available to discuss with you any questions you may have on Etrafon®, Afrin®, Tinactin®, Celestone®, Soluspan™, or any other Schering product.

G. D. Searle & Co.

Featured at the Searle exhibit will be Enovid for ovulation control and pregnancy and menstrual disturbances, and Flagyl, a potent, new trichomonacidal agent for trichomonal vaginitis, cervicitis, urethritis, and prostatitis.

Sherman Laboratories

Greater relief in osteoarthritis—without recourse to hazardous drugs—is provided by Persistin® in many patients. Each uncoated tablet contains: salicylsalicylic acid 7½ gr. (gastric insoluble, non-irritating, prolonged action); acetylsalicylic acid 2½ gr. (for prompt relief). Four tablets daily (one p.c. et. h.s.) usually provide day-long and night-long relief of pain and stiffness.

Siemens Medical of America, Inc.

Siemens Medical will display the complete Siemens line. Different new developments for therapy and diagnosis will be shown, and our representatives will be on hand to answer any questions you may have.

Smith Kline & French Laboratories

Featured will be our new diuretic, Dyazide. Each capsule contains 50 mg. of Dyrenium (brand of triamterene) and 25 mg. of hydrochlorothiazide.

E. R. Squibb and Sons

Stiefel Laboratories, Incorporated

Stiefel Laboratories will feature Brasivol, scrub cleanser for acne; Ichtho-cort Cream and Ointment, broad-acting therapy in acute, sub-acute, or chronic eczema; and acne-aid cream, new absorbent acne medication.

Syntex Laboratories, Inc.

Syntex Laboratories will feature Norinyl® (Norethindrone 2.0 mg. with mestranol 0.1 mg.) Tablets, an original steroid. Norinyl® 2 mg. supersedes barrier methods of contraception. Synalar® (fluocinolone acetonide), the topical corticosteroid designed to meet specific dermatologic needs, will also be featured. Synalar® has set a new standard of success in the treatment of a wide range of inflammatory dermatoses.

Systemedics, Inc.

Tilden-Yates Laboratories, Inc.

U. S. Vitamin & Pharmaceutical Corp.

The U. S. Vitamin & Pharmaceutical Corporation will display DBI® and DBI-TD®, as well as other leading pharmaceutical specialties and nutritional products.

Professional service representatives will be in attendance to help in answering any inquiries pertaining to the products on display, as well as any of their other products.

Unimed, Inc.

Serc—for vertigo—is a new chemical compound providing a new drug action for vertigo associated with Meniere's disease and other vestibular disturbances.

Algic and Algic-S. A. for allergic rhinitis is available for persistent allergy symptoms when an antihistamine alone is too little.

Ephoxamine for asthma is used when the "jittery" side action of ephedrine limits control in asthma.

Onycho-Phytex for nail fungus remains as an unequalled application for controlling nail fungus. It is an unusually effective topical treatment—virtually side effect free.

The Upjohn Company

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. Let them tell you about products of Upjohn research, designed to assist you in the practice of your profession.

Wallace Laboratories

Featured at the Wallace booth will be Solacen and other drugs of original research. Wallace representatives will be pleased to furnish information regarding our products and your related medical questions to assist you in your practice.

Warren-Teed Pharmaceuticals Inc.

The Warren-Teed exhibit highlights Modane®, a nutritional deconstipant for rehabilitation and relief of the atonic bowel, and Kaon®, potassium therapy well tolerated and rapidly absorbed in GI tract (potassium gluconate in tablets and palatable elixir). Our representatives will welcome the opportunity to discuss these and other Warren-Teed specialty items with you.

White Laboratories, Inc.

White Laboratories' exhibit features two important prescription products: Disophrol® Chronotab® Tablets and Disotuss™ Expectorant. Medical service representatives will be happy to discuss the many indications and the superior therapeutic effectiveness of these preparations.

Winthrop Laboratories

Winthrop representatives will be pleased to give you information on latest developments in the field of medicine.

Bicentennial Dinner-Dance

Tuesday, 7:00 p.m. May 17, 1966

Toastmaster
Richard I. Nevin

The National Anthem

Invocation
Father John G. Furniss, S.J.

Welcome
Nicholas A. Bertha, M.D., Chairman
Board of Trustees

Greetings
Mrs. Lewis C. Fritts, President
Woman's Auxiliary

Presentations
Fellow's Key:
to John J. Bedrick, M.D., President
by Charles H. Calvin, M.D.,
Immediate Past-President

Fellowette's Pin:
to Mrs. Lewis C. Fritts, President
Woman's Auxiliary
by John J. Bedrick, M.D., President

Guest Speaker
"One to Grow On"
Mason W. Gross, Ph.D., President,
Rutgers—The State University,
New Brunswick, New Jersey

Honoring
John J. Bedrick, M.D., President

Entertainment
Miss Lucia Albanese, Metropolitan Opera

Music
Martin King and His Orchestra



Mason W. Gross, Ph.D.

ONE PICTURE = A THOUSAND WORDS

We're not sure that Confucius really said that one picture was worth 1000 words. But no matter who said it, it's true. And at the Annual Meeting this year, you will find an exciting gallery of such "pictures": our exhibits . . . Historical, Informational, and Technical. See for yourself!

bicentennial

History of Medicine Exhibits

Sunday, May 15
12:00 noon to 5:00 p.m.

Monday-Tuesday, May 16-17
9:00 a.m. to 5:00 p.m.

For the Bicentennial Anniversary Meeting, the Board of Trustees directed that the Committee on Scientific Exhibits interest itself in exhibits dealing with the history of medicine rather than to focus on scientific exhibits, as in the past. By invitation, the following exhibits, portraying in historical fashion medical progress in various fields, will be presented through the courtesy of the individuals and organizations indicated:

A History of Medicine in Pictures

PARKE-DAVIS

Twenty-five of the original oil paintings in the series, "A History of Medicine in Pictures," covering the period from 1793 to the present, together with brief captions.

Crystal Gallery of Medicine

MERCK SHARP & DOHME

Microphotographs in color, showing the crystalline formation of chemical agents developed by the pharmaceutical industry.

Development of X-ray Tubes — From 1899 to 1966

RADIOLOGIC HEALTH PROGRAM, NEW JERSEY STATE DEPARTMENT OF HEALTH

A mounted collection of x-ray tubes used during the period 1899-1966. Included are air cooled, gas filled, rotating anode and therapy tubes, plus one of the smallest x-ray tubes made. Also shown will be a mobile x-ray unit manufactured in 1907 (still in operating condition) and a transistorized battery operated portable x-ray unit.

The Story of American Medical Education

AMERICAN MEDICAL ASSOCIATION

Explanations and illustrations of some of the people and places important to the historical advancement in medical education. Interesting replicas of old diplomas and licenses are displayed.

Medical Student Loan Program

MSNJ COMMITTEE ON MEDICAL STUDENT LOAN FUND

Charts and graphs are shown, outlining the growth and progress of the Fund during its nine years of operation. Descriptive literature will be available.

All members are invited to support the Fund with memorial, honorary, and/or Bicentenial commemorative contributions.

Pathfinders in Medicine

TEMPLE UNIVERSITY SCHOOL OF MEDICINE—FRED B. ROGERS, M.D.

Here are 10 panel portraits of pathfinders in medicine selected by the medical historian, Dr. Victor Robinson, for inscription upon the facade of Temple University School of Medicine in 1930. This series includes: Hippocrates (460-377 B.C.), Galen (130-200 A.D.), Andreas Vesalius (1514-1564), Ambroise Pare (1510-1590), William Harvey (1578-1657), Thomas Sydenham (1624-1689), Edward Jenner (1794-1823), Ephraim McDowell (1771-1830), Louis Pasteur (1822-1895), and Wilhelm Conrad Roentgen (1845-1923).

100 Years of Activity

NEW JERSEY STATE DEPARTMENT OF HEALTH

Activities of the New Jersey State Department of Health over the last 100 years are interestingly displayed.

Bicentennial of Progress

RUTGERS — THE STATE UNIVERSITY

Here is a pictorial display of the Bicentennial of Progress of The Medical Society of New Jersey and Rutgers—The State University.

Women in Medicine

THE WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA

Displayed here is a hemispheric pinpointing of medical missionaries graduated from Woman's Medical College. Also shown is the distribution of other graduates, together with many historical pictures.

11 Years of Community Volunteer Non-Profit Blood Banking

BERGEN COMMUNITY BLOOD BANK

See the story in graphs and pictures of the struggle and ups and downs in getting over to the public and doctors that a community blood bank on a volunteer basis is the best way to bank blood.

Medical Equipment of Yesteryear

MEDI-KAL PHYSICIANS & HOSPITAL SUPPLY COMPANY

The personal collection of Mr. Morton Winer, President of Medi-Kal, includes rare antique medical and surgical instruments and equipment, such

as a Josepn Zentmeyer brass microscope, a very rare "Oliver 6" pocket model mercurial monometer, a "Laennec" stethoscope, an early examining table, the iron-wheel wheel chair, and a patient scale of long ago . . . totaling over 50 unique and interesting items.

There Are Successes . . . There Are Failures . . .

WYETH LABORATORIES

Back-lit transparencies are shown, conveying some insight into the mechanics of research which takes place in the Wyeth Institute of Medical Research, indicating multi-disciplinary effort required in the development of new agents. "There are Failures . . ." charts the course of a new compound from the human need for it to its ultimate development and tribulations, as well as the costs before a compound can be developed to satisfy the medical need.

Another Anniversary

CHILDREN'S SPECIALIZED HOSPITAL

The Children's Specialized Hospital, founded in 1891, is celebrating its 75th anniversary of service on behalf of handicapped children. Old and new pictures of facilities and services which have been rendered to children with handicaps of more than two months' duration will be shown.

Pioneer Endocrinology

ORGANON INC.

A collection of twenty-four portraits is exhibited. These show prominent endocrinologists around the world who have contributed to the development of this medical discipline.

55 Years of Progress

THE ACADEMY OF MEDICINE OF NEW JERSEY

Historical highlights and present activities of the Academy of Medicine are pictorially and graphically displayed.

Medical Theory and Medical Practice: The Difference in 1849 to 1852 as Observed by Doctor E. R. Squibb

E. R. SQUIBB & SONS

Today medical literature is abundant, detailed, and accurate. But in 1849, when Doctor Edward Robinson Squibb took up his pen to write the Medical Journal of the U.S.S. Cumberland, medical literature was none of these things. What Doctor Squibb helped to encourage in his journal and subsequent observations at Jefferson Medical College was the publication of medical data to fill the gap between **sound medical theory** and **actual medical practice.**

He concentrated his remarks on post-graduate training, quarantine, cleanliness, and drug quality. If, in the past century, this gap between medical theory and medical practice has narrowed, it is in part due to Doctor Squibb's efforts. His comments and suggestions are the subject of this exhibit.

Early New Jersey Medicine

NEW JERSEY HISTORICAL SOCIETY

Antique surgical tools and medicine bottles . . . Medical Society of New Jersey Records, 1766-1888, Vol. 1 . . . Diary of Dr. Jabez Campfield, Revolutionary War, May 23-October 2, 1779 . . . Wickes, Stephen-History of Medicine in New Jersey . . . Pamphlet on "A History of the Use of Scutellaria Lateriflora . . . Pages from Dr. Lawrence Van Der Vere recipe book . . . Certificate to practice medicine for Dr. Lawrence and Dr. Henry Van Der Vere . . . Medical casebook of Dr. Marietta Woodruff of Boonton, New Jersey, 1874-1900 . . . Diary of Edward A. Pierson of Newark, 1836-1863 . . . Sweet and Robinson Record Book, 1858-1866.

Special Informational Exhibit

Medicare

SOCIAL SECURITY ADMINISTRATION

Panel exhibit depicting the various benefits that will be paid by Medicare. In addition, pamphlets describing the Medicare Program will be available.

Golden Merit Award Ceremony

Saturday Afternoon / May 14 / 2:00 p.m.

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Presiding
John J. Bedrick, M.D., President

Master of Ceremonies
Harry F. Suter, M.D., Chairman
Council on Public Relations

Marshals
Presidents of component societies whose members are receiving awards.

followed by

Reception for Award Recipients and Their Families

Bicentennial Luncheon

Tuesday Noon / May 17 / 12:30 p.m.

All members, official guests, and their wives; and members of the Woman's Auxiliary are cordially invited to attend ($4.00 per person).

Bicentennial Reception

Tuesday Evening / May 17 / 5:30 p.m.

The Atlantic City Convention Bureau cordially invites all members, official guests, and their wives, and members of the Woman's Auxiliary to attend a reception in honor of the Society's Bicentennial Anniversary (admission by badge).

Saturday-Tuesday
May 14-17, 1966
Chalfonte-Haddon Hall
Atlantic City

39th ANNUAL MEETING

Woman's Auxiliary to The Medical Society of New Jersey

Schedule of Events

Saturday, May 14, 1966

1:00 p.m. to 4:30 p.m.—Registration for Art Show
(Lobby Floor, Haddon Hall)

*2:00 p.m.—Golden Merit Award Ceremony
(Rutland Room, First Floor, Haddon Hall)

Sunday, May 15, 1966

9:30 a.m. to 4:30 p.m.—Registration
(Lobby Floor, Haddon Hall)

10:00 a.m. to 4:30 p.m.—Sale of Tickets (Lobby Floor, Haddon Hall) for: Annual President's Luncheon—Monday (Carolina Room, Chalfonte Hotel) All doctors' wives invited.

10:00 a.m.—Art Exhibit (Lobby Floor, Haddon Hall) County Press and Publicity Books, County Activities Pictorial Display.

10:30 a.m.—Pre-convention Board Meeting
(Pavilion Room, 15th Floor, Haddon Hall)

12:30 p.m.—Fellowettes' Luncheon
(Navajo Room, 15th Floor, Haddon Hall)

*3:00 p.m.—General Session on Medicare
(Vernon Room, Lounge Floor, Haddon Hall)

*6:00 p.m.—Reception Honoring President-Elect Jehl (Admission by Badge)
(Pennsylvania Room, Lounge Floor, Haddon Hall)

Monday, May 16, 1966

8:15 a.m.—to 9:00 a.m.—Coffee and buns will be served
(Tower Floor, 13th Floor, Haddon Hall)

8:15 a.m. to 4:30 p.m.—Registration
(Lobby Floor, Haddon Hall)

9:00 a.m. to 12 noon—Tickets on sale (Lobby Floor, Haddon Hall) for: Annual President's Luncheon—Monday (Carolina Room, Chalfonte Hotel) All doctors' wives invited.

9:00 a.m. to 12 noon—General Session
(West Room, 13th Floor, Haddon Hall)

12:30 p.m.—Annual President's Luncheon
(Carolina Room, Lounge Floor, Chalfonte)

*6:00 p.m.—Exhibitors' Reception and Buffet Dinner ($5.00 per person)
(Pennsylvania Room, Lounge Floor)

Tuesday, May 17, 1966

8:00 a.m.—Breakfast (New County Presidents guests of Auxiliary at breakfast)
(Mandarin Room, 13th Floor, Haddon Hall)

8:45 a.m.—Coffee and buns for members
(Hallway, 13th Floor, Haddon Hall)

9:00 a.m. to 1:00 p.m.—Registration
(Lobby Floor, Haddon Hall)

9:30 a.m.—Post-convention Board Meeting
(West Room, 13th Floor, Haddon Hall)

*12:30 p.m.—Luncheon ($4.00 per person)
(Vernon Room, Lounge Floor)

*2:30 p.m.—General Assembly on History and Medicine
(Pennsylvania Room, Lounge Floor)

*5:30 p.m.—Reception sponsored by the Atlantic City Convention Bureau (admission by badge)
(Lounge Floor)

*7:00 p.m.—Dinner Dance Honoring President Bedrick ($10.00 per person)
(Pennsylvania Room, Lounge Floor)

Tickets for Exhibitors' Party, Bicentennial Luncheon and Bicentennial Dinner on sale at MSNJ Registration Desk as follows:

Saturday—Stair Hall, Lounge Floor

Sunday, Monday and Tuesday—Exhibit Hall, Lobby Floor

Convention Committee

Chairman—Mrs. Samuel J. Kaman
Co-Chairman—Mrs. Hugh Kearney

* Special Bicentennial Events to which the Auxiliary members are cordially invited and urged to attend.

STATE ACTIVITIES

Second Injuries And Employment Of The Handicapped

Sometimes an employer hesitates to give a job to a one-armed or one-eyed worker. He fears he might be liable to total disability if an industrial accident aggravates the previous impairment. Every New Jersey doctor ought to know why this fear is, to a large extent, groundless. Accordingly, the Governor's Committee to Employ the Handicapped has prepared the following explanation.

The One Per Cent or Second Injury Fund — also known as the Subsequent Injury Fund — is created by annual contributions of insurance companies and self-insurors. The contribution is one per cent of the total compensation paid out by the insurance company or self-insuror during the previous year.

The Fund, administered by the Commissioner of Labor and Industry, is used to provide benefits for employees who become totally disabled as a result of successive injuries, each of which alone would cause only partial disability. In such cases of subsequent injury, the employer is obligated to pay compensation only for the disability which resulted from the second injury. The Fund pays the remainder of the compensation. The law governing the Fund is complex, and the advice of counsel is suggested on any matter that may involve it.

Job placement for the handicapped is made more difficult by the fact that employers fear they will be exposed to higher workmen's compensation costs if they hire a disabled applicant. Employers want to hire the handicapped; but they do not want to be penalized for doing so. The employer's awareness of the skills, dependability, loyalty, and safety records of the handicapped may be overshadowed by the knowledge that if a handicapped worker is involved in a job accident, its effects may be more severe than if a non-handicapped worker had the same accident. Should a one-armed or one-legged worker lose a second arm or leg in a work accident, the employer fears that he might be liable for workmen's compensation benefits for a *total* disability, rather than for *partial* disability.

The Second Injury Fund provides benefits for a worker who is totally and permanently disabled as the result of an industrial injury, if such person had previously been permanently and partially disabled from some other cause, irrespective of whether the previous injury or condition was industrial or non-industrial in origin (R.S. 34:15-94 et seq.).

By removing the employer's fear of increased workmen's compensation costs, the Second Injury Fund enhances employment opportunities for disabled workers. In paying the totally disabled worker full benefits for his resulting disability, the Fund relieves him of the need to seek charity for himself and his family. Since the Fund lessens the possibility that the employer will be exposed to an unfair penalty, he may feel free to give closer consideration to the abilities of the handicapped jobseeker.

New Rule On Malpractice Claims

Under date of February 28, 1966, the Administrative Director of the Courts of the State of New Jersey issued the following news release:

The New Jersey Supreme Court and The Medical Society of New Jersey announced today the adoption of a new program for handling medical malpractice claims. The purpose of the program is to discourage baseless professional liability cases and to make expert medical testimony available to claimants in those cases where there is a reasonable basis for the claim.

Where the claimant and the doctor (against whom the claim is made) are agreeable, all the pertinent facts will be submitted to an impartial court-appointed panel composed of two doctors, two lawyers, and a former judge. If the panel finds no reasonable basis for the claim, it is anticipated that the claimant will drop the matter. If the panel finds that there *is* a reasonable basis for the claim, and the claimant agreed in advance to be bound by the panel's finding, the Medical Society will make expert medical witnesses available to the claimant.

The Medical Society of New Jersey – through its President, Dr. John J. Bedrick – expressed satisfaction with the Supreme Court rules establishing the program: "This Rule represents the culmination of joint efforts on the part of our Society and the New Jersey Bench and Bar that go back for upwards of a decade. It is our shared hope that this newly established voluntary, impartial mechanism will prove to be an efficient means whereby malpractice claims can be equitably and expeditiously dealt with. If it does, it will be a boon to all concerned."

A copy of the Rule as adopted by the Supreme Court is presented below:

Rule 4:25B is adopted to read as follows:

RULE 4:25B. PROFESSIONAL LIABILITY CLAIMS AGAINST MEMBERS OF MEDICAL PROFESSION; PROCEDURE

4:25B-1. Scope of Rule

The procedure set forth in these rules is for the common interest of the public, the medical profession and the legal profession in the handling of medical professional liability claims with the view to (a) discouraging baseless professional liability cases and (b) making expert medical testimony available to claimants in those professional liability cases where there is a reasonable basis for the claim.

Note: Adopted February 21, 1966 to be effective immediately.

4:25B-2. Panel of Doctors, Former Judges and Lawyers

For purposes of this rule the Administrative Director of the Courts shall maintain a panel of doctors designated by The Medical Society of New Jersey and a panel of attorneys designated by the Supreme Court.

Note: Adopted February 21, 1966 to be effective immediately.

4:25B-3. Claims; Hearings; Notification; Subpanels

(a) All persons, or their representative, claiming damages by reason of injury or death resulting from alleged medical negligence shall be encouraged to make an informal and voluntary submission of their claim, against any and all doctors against whom they believe there is a reasonable basis for claim, to a subpanel for evaluation either prior to or after the institution of legal action. It is preferable that the submission be prior to commencement of legal action.

(b) The claim shall be made on forms to be provided, upon request, by the Administrative Director of the Courts.

(c) The Administrative Director of the Courts shall notify the doctor, or doctors, of the claim and request their consent to a hearing before the subpanel. The notice shall advise the doctor to consult with his attorney and insurance carrier before giving consent.

(d) Upon receipt of the claim and consent, the Administrative Director of the Courts shall notify the claimant and his attorney and the doctor and his attorney of the date, time and place of the hearing and invite them to attend. The notification shall contain the names of the members of the subpanel hearing the matter.

The doctor, his personal counsel and counsel for insurance carrier, as well as claimant and his counsel, may attend.

Note: Adopted February 21, 1966 to be effective immediately.

4:25B-4. Submission of Claim to Subpanel

(a) The claim shall be submitted to a subpanel of persons provided for in Rule 4:25B for evaluation. The subpanel shall be composed of two doctors, two attorneys, and a

former justice of the Supreme Court or former judge of the Superior or County Court, who shall be designated as Chairman. The Chairman shall vote only in case of a tie.

(b) The subpanel shall be named by the Administrative Director of the Courts. The place and time of hearing shall be fixed by the Administrative Director of the Courts.

Note: Adopted February 21, 1966 to be effective immediately.

4:25B-5. Procedure Before Subpanel; Finding

(a) The claimant shall set the facts before the subpanel in whatever form he thinks appropriate. He may do so in the form of a narrative statement by his lawyer, or in the usual courtroom form of question and answer, or by written statement. Witnesses may be called or sworn or unsworn statements of witnesses may be produced.

With the consent of claimant, the attorney for the doctor (personal or insurance) may question the claimant or a witness.

When the claimant has finished with his presentation, the doctor may in like manner put forth his version of the facts in any form he thinks appropriate.

With the consent of the doctor, the attorney for the claimant may question the doctor or his witness.

(b) Both parties, through their respective attorneys, shall produce the original or copies of all hospital and other records, including readings, x-rays, and reports necessary to a full presentation of the facts.

(c) After an evaluation of the information submitted, the subpanel shall advise the parties and their attorneys either "We find that there is a reasonable basis for the claim" or "We find that there is no reasonable basis for the claim." No opinion shall be given with respect to the extent of damages.

Note: Adopted February 21, 1966 to be effective immediately.

4:25B-6. Recommendation After Finding

When the subpanel advises that there is no reasonable basis for the claim, it shall recommend to the claimant either that no legal action be instituted, or, if legal proceedings are pending, that they be discontinued. When the subpanel advises that there is a reasonable basis for the claim it shall recommend that an amicable settlement of the claim be considered.

Note: Adopted February 21, 1966 to be effective immediately.

4:25B-7. Expert Witnesses Furnished in Certain Cases

(a) The claimant may (but need not) agree in writing in advance not to institute legal proceedings or to dismiss any proceedings that may be pending in the event the subpanel is of the opinion that there is no reasonable basis for the claim.

(b) If the claimant does agree in writing, as provided in paragraph (a) of this rule, and if the subpanel is of the opinion that there is a reasonable basis for the claim, the Administrative Director of the Courts will supply the names of three expert medical witnesses from a list compiled by The Medical Society of New Jersey, all or any to serve at a reasonable fee to be paid by the claimant.

Note: Adopted February 21, 1966 to be effective immediately.

4:25B-8. Withdrawal of Counsel

In the event the subpanel is of the opinion that there is no reasonable basis for the claim, the attorney for the claimant shall be precluded from initiating any action on behalf of the claimant or, if an action has previously been instituted, he shall withdraw therefrom.

This shall not prevent the claimant from obtaining other counsel, if he so desires.

Note: Adopted February 21, 1966 to be effective immediately.

4:25B-9. Proceedings to be in Camera

All proceedings, records, findings and recom-

mendations of the subpanel shall be confidential and shall not be used in any other proceeding or be otherwise disclosed without the consent of all parties. All proceedings shall be in camera and no records shall be made thereof. All exhibits shall be returned at the conclusion of the proceedings to the parties submitting them.

Note: Adopted February 21, 1966 to be effective immediately.

4:25B-10. Secrecy

The circumstances under which an expert medical witness was made available, or the fact that he was made available under this rule, shall not be made known to the trier of the facts.

Note: Adopted February 21, 1966 to be effective immediately.

4:25B-11. Rehearing

The subpanel may grant a single rehearing of any claim, under the same conditions controlling the initial hearing, upon the affirmative votes of three members of the subpanel, who voted on the original determination.

A rehearing of any claim shall not be granted if the claimant or doctor has substituted counsel.

Note: Adopted February 21, 1966 to be effective immediately.

Delays In Signing Death Certificates

Physicians at patients' deaths have had their responsibilities more sharply defined by the enactment of Chapter 78, Laws of 1965. Under R.S. 26:6-8 as amended, the pertinent sentence reads "Within a reasonable time, not to exceed 24 hours after the pronouncement of death, the physician shall execute the medical certification."

The burial or other disposition of the body cannot take place without a burial permit. This permit is issued only in exchange for a properly completed death certificate. Your delay in signing the certificate can interfere seriously with the funeral plans of the decedent's family or executor.

If the exact cause of a death from natural causes cannot be stated until autopsy is complete, the medical certification may state "Exact cause unknown pending autopsy results." At a later date the certification may be amended by use of a "correction form." The initial statement is enough to enable the funeral director to get the burial permit.

Your cooperation in signing a death certificate promptly will be of great help to the State Health Department and to the families concerned.

Our New History

A comprehensive one-volume history of the nation's oldest state medical society, *The Healing Art: The Medical Society of New Jersey through Two Centuries, 1766-1966,* will counterpoint our bicentennial celebration at Atlantic City, May 14 to 18, 1966. Carefully compiled by the Society's archivist-historian Fred B. Rogers, M.D., with the collaboration of Mrs. Arlene R. Sayre, this chronicle provides a readable keepsake and factual record of the medical and cultural heritage of the Garden State.

A 420-page book with 75 illustrations, its cover design and page layout were done by Homer Hill, eminent New Jersey artist, who also designed the special Bicentennial year cover for the JOURNAL. The book is being produced by The Printing Corporation of Amer-

ica, which has published among other outstanding volumes the *Life* series on geography, history and the arts. Mr. Leonard D. Metz, Philadelphia representative of The Printing Corporation of America, has expedited the production, as he does the printing of the Medical Society's JOURNAL each month.

A copy of *The Healing Art* will be mailed to each member of The Medical Society of New Jersey. Additional copie swill be available for purchase at $10.00 per copy to other professional groups, interested persons, and the general public as part of the Bicentennia observance. Hospital gift shops, professional and other libraries, historical societies, and civic bodies have already indicated their desire for copies. An attractive, accurate account, the book is the product of several years of meticulous research and writing and should be useful as a souce of authoritative reference for years to come.

Production of this volume has had the expert attention of the members of the Special Committee on Bicentennial History, working with the Archivist-Historian. They are: Dr. Emanuel M. Satulsky, Chairman and Secretary, Board of Trustees, Dr. Samuel J. Lloyd, Dr. George B. Sharbaugh (who is also Chairman of the JOURNAL Publication Committee), and Mr. Richard I. Nevin, Executive Director. To Mr. Nevin and his staff members, Miss Theresa E. Goeke, Executive Assistant and Assistant Editor of the JOURNAL, and Mrs. Edith L. Madden, Administrative Secretary and Convention Manager of the Society, go thanks for critical reading and technical assistance. Prepared with the cooperative interest and help of many, *The Healing Art* documents two centuries of distinguished professional achievement.

Patronize Our Advertisers

The companies and places which advertise in this JOURNAL merit your support. The fact that their advertisements are here is assurance of their reputability. By placing these notices in these pages, they assist your JOURNAL and your Society.

BICENTENNIAL CELEBRATION
May 14-16, 1966
Haddon Hall, Atlantic City

Report Your Adverse Drug Reactions!

The American Medical Association through its Registry on Adverse Reactions is encouraging the wider reporting of drug reactions by physicians and hospitals. They are interested in obtaining unpublished data on serious, unusual, or unexpected reactions, even though such observations may be based only on suspicion or circumstantial evidence. Such data are essential if early alerting of the medical profession to unsuspected hazards of drugs is to be a reality.

Send your reports to Council on Drugs, AMA, 535 North Dearborn Street, Chicago 60610.

For Your Travelling Patients

The Public Health Service now has a new edition of *Immunization Information for International Travel.* You can get it for the small sum of 35 cents,* and it includes vaccination requirements for all countries from Afghanistan to Zambia. It tells you what vaccination you (or your patients) need to get back to New York, and also what immunizations you should have or give for your own (or the patients') protection. It contains information about those indispensable yellow cards the traveller had better carry. And it includes some interesting maps showing endemic areas for malaria, dengue, and yellow fever . . . and all sorts of useful sanitary and medical information for travellers.

* Tape a quarter and a dime to a card, mail it to Government Printing Office, Washington, D.C. 20402 and ask for Public Health Service Publication 384—"Immunization Information."

BICENTENNALIA

William Augustus Newell: Physician, Governor, Congressman

In August 1965, at Twin Lights, Sandy Hook State Park, a plaque was dedicated honoring Dr. William Augustus Newell, "father" of the federal life saving service, now a part of the U.S. Coast Guard. The plaque noted that on August 14, 1848, President James K. Polk signed Newell's Resolution . . . "providing surf boards, rockets, carronades, and other necessary apparatus for the better preservation of life and property from ship wrecks on the coast of New Jersey between Sandy Hook and Little Egg Harbor."

Dr. Newell, though he rose high in public office — [Governor of New Jersey and of the Washington Territory and Congressman from New Jersey] — did not forsake his chosen profession of medicine. During a long career his medical practice ranged from seaside and rural New Jersey to The White House and the Pacific Northwest.

William Augustus Newell came from a family known for its medical men. Among his forbears, Dr. James Newell of Freehold had been the sixth president of The Medical Society of New Jersey in 1772, and his son, Dr. Elisha Newell of Allentown, became its twentieth president in 1795. William was born at Franklin, Ohio, on September 5, 1817, his parents having temporarily moved there from Freehold, N.J. The son was graduated from Rutgers in 1836 and received his M.D. degree from the University of Pennsylvania three years later.

Young Dr. Newell began practice with an uncle, Dr. G. Augustus Hankinson, at Manahawkin, on Barnegat Bay in Ocean County. There, in 1840, he witnessed the burial of thirteen victims from the wreck of an Austrian brig, the *Count Perasto*. These 13 people had drowned within sight of shore for want of rescue facilities. This tragedy prompted an idea for a life saving plan and service — which the doctor subsequently led to enactment.

After a year at Manahawkin, Newell moved to Imlaystown in Monmouth County. Here, in 1843, he accomplished a remarkable plastic surgical procedure which was reported as follows in the *Monmouth Inquirer:* "An operation for the formation of a new eyelid was performed in Upper Freehold Township by Dr. William A. Newell of Imlaystown. The material from which the lid was formed was taken from the cheek of the patient, who had suffered from pain and inconvenience for fourteen years from continual exposure of the eye to light and the atmosphere. The operation was so successful as to leave scarcely a vestige of the unsightly deformity."

Joining The Medical Society of New Jersey in 1839, Dr. Newell served as a delegate to the state body and was, for a term, president of the Monmouth County Component Medical Society. In 1844 he settled in Allentown and between periods of elected office practiced there. His wife, Joanna Van Deursen, was the daughter of a prominent physician in New Brunswick. They had a son and a grandson who became physicians — at Allentown and Trenton respectively.

Dr. William A. Newell was elected to the U.S. House of Representatives in 1847 and served four terms. While in Congress, in 1848, he treated former president John Quincy Adams during his last illness. A close friend of Abraham Lincoln — they lived in the same Washington boarding house for a while — he attended the Lincoln family professionally, was appointed physician to The White House in 1864. He was a New Jersey representative at the funeral of President Lincoln.

From 1857 to 1860, Dr. Newell was Governor of New Jersey. Undaunted by a snowstorm on the January day before his inauguration, he walked the fifteen mile distance from Allentown to Trenton for the event!

In 1880, President Rutherford B. Hayes appointed him Governor of the Washington Territory — a post he held for four years. After serving for six years as Commissioner of Indian Affairs he returned to medical practice in 1890, at Olympia, Washington. There he was physician to the Soldiers and Sailors Home for the new State of Washington. Returning to New Jersey in 1899, he resumed practice at Allentown. Here he died on August 8, 1901, and was buried in the Presbyterian Churchyard of the town.

Fred B. Rogers, M.D.

THE MEDICAL SOCIETY OF NEW JERSEY
BICENTENNIAL ANNIVERSARY MEETING

Saturday-Wednesday, May 14-18, 1966
Haddon Hall, Atlantic City

DAILY SCHEDULE

Friday, May 13, 1966
5:00 p.m.—Board of Trustees

Saturday, May 14, 1966
10:00 a.m.—Registration Opens
2:00 p.m.—Golden Merit Award Ceremony
followed by
Reception for Award Recipients and Their Families
4:00 p.m.—House of Delegates
followed by
Open Discussion on Medical-Surgical Plan
5:30 p.m.—Hudson County Reception for President Bedrick (by invitation only)
8:00 p.m.—Nominating Committee

Sunday, May 15, 1966
10:45 a.m.—Reference Committees
12:00 noon—Exhibits Open
2:00 p.m.—House of Delegates (election)
3:00 p.m.—General Session on Medicare
6:00 p.m.—Reception for President-Elect Jehl

Monday, May 16, 1966
9:30 a.m.—Scientific Sessions:
Clinical Pathology, Medicine, Rheumatism
Gastroenterology and Proctology, Metabolism, Surgery
Allergy, Dermatology, Pediatrics
Ophthalmology, Otolaryngology
12:30 p.m.—Special Luncheons
2:00 p.m.—Scientific Sessions:
Anesthesiology, Obstetrics and Gynecology
Cardiovascular Diseases, Chest Diseases, General Practice
Radiology, Urology
Psychiatry and Neurology
6:00 p.m.—Reception and Dinner for Technical Exhibitors ($5.00 per person)

Bicentennial Day—Tuesday, May 17, 1966
9:30 a.m.—Scientific Program
12:30 p.m.—Luncheon
2:30 p.m.—General Assembly on History and Medicine
5:00 p.m.—Exhibits Close
5:30 p.m.—Reception by Atlantic City Convention Bureau
7:00 p.m.—Dinner-Dance ($10.00 per person)

Wednesday, May 18, 1966
9:30 a.m.—House of Delegates
12:30 p.m.—Delegates' Luncheon
1:30 p.m.—House of Delegates—continued
3:00 p.m.—Registration Closes
4:00 p.m.—Board of Trustees

OBITUARIES

Dr. David Goldberg

Dr. David Goldberg died on February 9, 1966 at the age of 70. He received his M.D. at the University of Vermont in 1924, and he was a general practitioner. In these two short sentences are the simple facts. "We in Bergen County thought a lot of him," said its secretary, sending to the editorial office a tribute from the Bergen Evening *Record*. That memorial is here abstracted.

"A man died in Westwood last week, and we're all so much poorer for his going. His patients were people, not charts. Some he bullied, some he chided. Others felt a warmth more healing than any balm he prescribed. Dr. David was a man you called when you were sore beset. And he was always there. There were no golfing Wednesdays. And at the age of 60, a child's cry could bring him out in the middle of the night."

Dr. William M. Winn

Vacation turned into tragedy on February 28, 1966, when Dr. William M. Winn, a prominent Middlesex County obstetrician and gynecologist, died while on holiday in California. Born in Bayonne in 1910, he received his baccalaureate from Brown and his medical degree from Trinity College in Dublin, Ireland, in 1940. The war was on then, though the United States was not yet in it, and Dr. Winn joined the British Army Medical Corps and served in Italy and Africa. In 1948 he came to Middlesex County and set up his office in Perth Amboy for private practice. Dr. Winn was attending obstetrician and gynecologist at the General Hospital, and was vice-president of the medical staff of the South Amboy Memorial Hospital. He was active in civic and religious affairs throughout Middlesex County.

ANNOUNCEMENTS

The Doctor and The Defective Child

On Friday, April 22, our State Health Department is sponsoring an all-day symposium on the physician's role in the care of the mentally retarded. This is at the Cherry Hill Inn, Route 38, just north of Camden. The meeting opens at 9 a.m. and adjourns at 5 p.m. A star-studded faculty will discuss the physiologic, biochemical, prenatal, perinatal, and genetic aspects of the problem.

Symposium On Middle Ear Surgery

On your way back from the Annual Meeting of The Medical Society of New Jersey on Wednesday, May 18, stop in at the Beth Israel Hospital in Newark for an all day (9 a.m. to 5 p.m.) seminar on "Modern Trends in Middle Ear Surgery." Under sponsorship of the Academy of Medicine, co-sponsored by the New Jersey Academy of Otolaryngology, and supported in part by Ciba Pharmaceuticals and Warner Chilcott Laboratories, this program is headed by a star-studded faculty. For details, write to Dr. Leon J. Schwartz, 162 Chestnut Street, Rutherford, N.J.

Morality in Medicine

A dinner and seminar are scheduled for May 11 at the Seton Hall University in South Orange. The subject is "Morality in Medicine." The panelists are chosen from religious leaders in the northeastern part of the United States. You are welcome. The dinner is at 6:00 p.m. and the seminar, at 7:30 p.m. For more details, write to the President of Seton Hall, South Orange.

Blood Bank Seminar

Wednesday evening, May 25, has been set aside for a symposium on indications for the use of blood and plasma components and also on the significance of the Coombs tests. Participants include Dr. Robert L. Rosenthal, Director of Hematology and Blood Bank at the Joint Disease Hospital in New York, and Dr. Mary Crawford, Associate Professor of the Philadelphia Blood Center. The meeting will be held at the Blood Bank office at 20 Hudson Place in Hoboken. For details, write to the Community Blood Bank and Serum Service at that address.

Accident Prevention Meeting

On Tuesday, April 12, at 9 p.m., a program on accident prevention will be presented at the Rahway Hospital on Stone Street in Rahway. Sponsored by the New Jersey Academy of Pediatrics and the staff of the Rahway Hospital, this meeting will feature a special symposium on accident prevention and a discussion by several surgeons and teachers.

Cardiac Surgery

Dr. William Lemmon, Assistant Professor of Surgery at Halmemann, will present a paper on "The Surgery of Coronary Artery Disease," at the Middlesex General Hospital in New Brunswick, on April 12 at 9 p.m. The New Jersey Department of Health and the Academy of Medicine of New Jersey are the joint sponsors.

Cancer — 1966

An unusual program on "New Facets of Cancer in 1966" is announced for Thursday, May 5, from 1 to 10 p.m., at Temple University Hospital. The program will include a discussion of the cancer risk of contraceptive pills, the alleged virus etiology of cancer, and new concepts on the prevention of malignancy. For details, write to the Department of Continuing Education, Temple University School of Medicine, Broad and Ontario Streets, Philadelphia 19140.

BOOK REVIEWS

The Importance of Lying. Arnold M. Ludwig, M.D. Springfield, Illinois, 1965, Charles C. Thomas. Pp. 238. ($9.75)

Sooner or later every doctor is faced with the problem of whether to tell a patient a blunt and cruel truth or whether to tell him a graceful and solacing lie. Most of us opt for the lie. There are always a few purists, however, who argue that truth is always virtuous and lying is always evil. Dr. Ludwig's interesting and witty book should be prescribed reading for the sanctimonious souls who think sincerity and truth are complete virtues in themselves.

Dr. Ludwig here demonstrates that some degree of deception and lying is essential to preserve good human relationships, to protect one against many of the pressures to which he is subjected, to advance in one's business or profession, and to bring up children properly. If you do not teach your child to say "thank you, I had a nice time" to his hostess at the first party he goes to, you are in danger of bringing up an unmannerly brat. Ludwig tries to distinguish here between malicious lies that are destructive and virtuous lies that are gracious or protective. As he points out, every woman who wears a girdle is, in a sense, practicing a form of deceit. Ludwig has no difficulty showing how much of lying and deceit are involved in many human activities from making love to making money. The administration of justice, professional advancement, advertising, politics, diplomacy, and marriage are all examples of human relationships in which a dash of hypocrisy or a tincture of deception will be helpful in maintaining the relationships on a pleasant basis. Ths book should really not shock anyone. He who says that he never deviates from the truth is surely a liar.

WILLIAM S. SCHRAM, M.D.

Principles of Chest Roentgenology. Benjamin Felson, M.D., Aaron S. Weinstein, M.D., and Harold B. Spitz, M.D. Philadelphia, 1965, Saunders. Pp. 221, illustrated. ($6.00)

The three authors (from the University of Cincinnati), have successfully written a programed text for physicians and students of medicine to help then understand the findings revealed in a chest radiograph.

The reader must have a background of basic science training in medicine. With this as a launching pad, he will find the logical development in the text, from the basic principles for radiographic image production to the final clinical analysis of the variation in contrast to be fun reading; and factually rewarding, too. It will help the doctor to understand his patient's pathology better, and it will expedite the proper care for the patient.

The authors (who are radiologists) have directed the material to be useful to student physicians and practicing physicians. I also recommend it as an excellent review for radiologists as well as providing a good insight to ways of making his radiographic interpretation more lucid to the referring physician.

The technic of developing the material in the book as a "Programed Text" has made the reading of the printed word and the assemblage of the factual material more like a game than a study. It includes an analysis of the pathologic processes that involve the lungs, the pleura, and the rib cage. It offers hints on differential diagnosis. It interjects references to facts and fancy that stimulate the readers logical assimilation of workable information.

I recommend their "study exercise" to all physicians practicing the healing arts. I recommend it, especially, to the medical student and the house officer. Everyone who studies it through, as directed by the authors, will come away feeling that it was time well spent for learning as well as entertainment.

JOHN J. THOMPSON, M.D.

Diseases of the Newborn. By Alexander J. Schaffer, M.D. Second Edition. Philadelphia, 1965, Saunders. Pp. 1023, illustrated. ($22.00)

Five years have passed since the first edition of this book. The author has incorporated important additions and changes that bring this second edition up to date, and make it 150 pages longer. A new section (Constellation of Congenital Malformations — Odd-Looking Babies) has been added; these include gross chromosomal aberrations and other multiple malformation syndromes. There is a new chapter on calcium and phosphorus metabolism. Other chapters have been enlarged and additional diseases are discussed.

The book has retained its original formula by being clearly written and in large print. Dr. Schaffer's massive background in practice and teaching reveals itself throughout the book. Case histories and illustrations are present in abundance.

The appendices contain valuable and complete guides for full-term and premature infant care, resuscitation in the delivery room, step-by-step management of erythroblastosis foetalis, and a pharmacopeia for the neonatal period.

The section on "Disorders of the Cardiovascular System" by Dr. Milton Markowitz has been completely revised and reads beautifully. Dr. Lawrence Finberg's new section on "Fluid Balance in the Neonate" fills a void that was noticed in the first edition.

All in all, this book is still the Bible on newborn diseases. It is not intended to be used solely as a reference text. It should be read thoroughly by all pediatricians who want security in the knowledge of neonatology. General practitioners, medical students, pediatric residents, and all others interested in pediatrics would find this a most valuable reference work.

MILTON PRYSTOWSKY, M.D.

Electrocardiography and Vectorcardiography. Lawrence E. Lamb, M.D., Philadelphia, 1965, Saunders. Pp. 609, illustrated. ($17.00)

This fine piece of work approaches its subject from the standpoint of vector analysis and cellular electrophysiology. Lamb devotes the first portion of his book to a fundamental (but not elementary) discussion of instrumentation and vector analysis in electrophysical and mathematical terms. He then deals with the normal electrocardiogram, based on his work

in reviewing the graphs of hundreds of thousands of U.S. Air Force flying personnel. From this experience, he repeatedly makes a plea for serial electrocardiograms. It is his contention that previously accepted "norms" reveal changes briefly from time to time and then revert to normal again; that this is evidence of silent myocardial pathology. Also, that minor changes which on a single observation would fall into the "normal range," on comparison with a prior normal graph, reveal a serial change of significance.

The author holds to the view that previously accepted concepts of the origin of ECG changes in infarction are, indeed, only theories and not facts. He says that conduction abnormalities (and not muscle damage) are the basis for those changes. He makes out a good case for it in great detail. He deals with the W-P-W syndrome at length, as he does T wave changes, arrhythmias, and ventricular conduction defects.

The book is profusely illustrated with diagrams, electrocardiograms, and vectorcardiograms, all of which are amply explained in subtitles.

HARVEY E. NUSSBAUM, M.D.

Surgery of the Parotid Gland. R. Anderson, M.D. and L. T. Byars, M.D. St. Louis, 1965, Mosby. Pp. 77 with 124 illustrations. ($12.75)

This treatise on the surgery of the parotid gland offers a definite contribution to the surgery of this specialized area about which (despite extensive writing on the subject in the past 30 years) confusion is considerable. This text admirably outlines the indicated procedure of surgical attack and vividly presents the plastic repair of the defects caused by the operation. The chapters on the anatomy and pathology of the gland are enhanced by excellent illustrations and clear discriptions.

Diagnostic procedures discussed in the third chapter leave nothing to be added. However, I revert to the complications and secondary reconstruction outlined in the last chapter as being the strongest point of the entire text and is, to my way of thinking, the most worthwhile presentation in the book.

Reading this publication should make it clear that parotid gland surgery should not be undertaken by the average, even the experienced, surgeon unless he has become especially skillful in this procedure. As a text and reference book for the medical student, it contains all the material that could be sought for in the teaching of this subject.

DANIEL F. FEATHERSTON, M.D.

Report of the Commission on Drug Safety. L. T. Coggeshall, M.D., Chairman. Federation of American Societies for Experimental Biology, 9650 Wisconsin Ave., N. W., Washington, D. C. 20014. Pp. 228.

The Commission on Drug Safety, created in 1962, concluded its deliberations in 1964. This short life span was itself recognition of the fact that the Commission could not itself solve the problem of drug safety.

The report encompasses the results of new research, their applications in clinical pharmacology, and their practical uses in medicine. The roles of the universities, industry, Government, and the public are also elaborated upon in respect to drug safety.

A special report from a Subcommittee in Teratology is of great interest, since the public became sensitized to the problem after the thalidomide tragedy. The creation of an "Institute for Prenatal Pharmacology" might be very useful. If it is established, it will owe its initiation to this report.

Another interesting part of this report reveals that the control of licit narcotics in the United States is surrounded by exceptional safeguards for the public.

This report is of value to members of the industry, research workers in clinical pharmacology, and personnel engaged in protecting the public from the adverse effects of drugs. It should be included in the working library of colleges of medicine and of pharmacy. And it wouldn't hurt law schools to stock the book, either.

HAROLD S. FELDMAN, M.D.

Food Facts For Teenagers. Margaret Belais Salmon, B.S., M.S. Illinois, 1965, Charles C. Thomas, Publishers. Pp. 129. ($5.75)

Here is an excellent book for teenagers interested in good nutrition. It deals first with food misinformation and fallacies, in question-and-answer form. The author stresses the common problems which perplex teenagers. For example, the statement that toast is less fattening than bread is labelled a fallacy. Omitting breakfast is deplored as a poor method of weight reduction. However, the fact that all kinds of liver contain larger amounts of iron and vitamins A, C, and B complex than do other meats will not awaken the palatal delights of our teenagers.

Vitamins are defined as the "spark-plugs" of life. Mrs. Salmon includes lists of the vitamin content of the common foods. The teenager is invited to choose wisely. Also presented is a sensible discussion about calories; a review of the basic food groups; methods of weight loss and weight gain; and several interesting low-calorie dessert recipes with teenage appeal.

The teenager would be wise to read this book for an understanding of good nutrition habits.

HARVEY P. EINHORN, M.D.

The Biosocial Basis of Mental Retardation. Edited by S. F. Osler, Ph.D. and R. E. Cooke, M.D. Baltimore, 1965, Johns Hopkins Press. Pp. 151. ($5.50)

Medical schools have always tended to underplay mental retardation. Few M.D.'s — including psychiatrists — have had any exposure in depth to the problem of mental deficiency. Most psychologists have scant interest, apart from a diagnostic one. So, in general, the retardate has been nobody's child. Possibly the primary factor in recent interest here has been the concern of the late President John F. Kennedy, and the fact that when even so distinguished a family can tell the world that they share this problem, there is no longer any reason for sweeping it under the rug. This book is dedicated to Mr. Kennedy's memory. It is made up of seven lectures given at Johns Hopkins covering a wide spectrum of causative factors, as well as diagnostic, preventive, and remedial ones. The book is well-illustrated, and affords its readers a sound and solid platform for understanding many little-known cultural and remedial aspects of this serious personal and social problem.

HERBERT BOEHM, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

APRIL, 1966 • VOL. XXXIX, NO. 4

POLONIUM^{210} IN PULMONARY TISSUES OF CIGARETTE SMOKERS

When amounts of the radioactive isotope Po^{210} were measured in lung tissue, higher concentrations were found in cigarette smokers than in nonsmokers. The evidence indicates that Po^{210} may be a factor in the development of bronchial cancer in cigarette smokers.

Cigarette smoke contains trace amounts of an alpha-particle-emitting radioactive element, polonium^{210} (Po^{210}), a naturally occurring daughter isotope of radium.^{226} In establishing whether this source of radiation exposure may be involved in the initiation of bronchial cancer in smokers, an important step is to show that pulmonary tissues of smokers, particularly certain regions of the bronchial epithelium, contain more of this element than those of nonsmokers.

The present investigation was undertaken to measure Po^{210} concentrations in various pulmonary tissues of smokers and nonsmokers.

Lung specimens from 36 patients were studied. The specimens were either whole lungs obtained at autopsy or whole lungs or lobes surgically removed. Twenty-five of the patients were cigarette smokers, two were pipe smokers, one was a former cigarette smoker, and eight had never smoked.

Radioactivity was measured in gas-flow proportional counters, with background rates of 0.2 to 0.6 counts per hour, and efficiencies of 51 per cent for polonium alpha particles.

The Po^{210} concentrations found in lung parenchyma, peribronchial lymph nodes, and bronchial epithelium are expressed as picocuries (10^{-12} curies, or 2.2 disintegrations per minute) of Po^{210} per gram of wet tissue. The average concentration in peripheral parenchyma of current cigarette smokers was 0.0074 picocurie per gram as compared with 0.0016 for nonsmokers. Parenchymal concentrations in the two pipe smokers were similar to those of nonsmokers.

No correlation was found between concentrations in the lung parenchyma with total cigarettes smoked expressed as pack years (packages per day times number of years smoked), or with the age of the individual at death. However, there was a trend toward higher Po^{210} levels in persons whose daily cigarette consumption was high.

Correlation with daily cigarette consumption, but not with total cigarettes smoked, is not unexpected because of the rapid clearance time for particulates by the lung and the relatively short half-life of the polonium isotope. When parenchymal Po^{210} was studied as a function of time since cessation of smoking, a significant trend toward higher levels was evident only in those who had smoked up to 24 hours or less before death or surgery, but the scatter was great. The parenchymal Po^{210} concentration in the one former cigarette smoker was very low (0.0015 picocurie per gram).

JOHN B. LITTLE, M.D.; EDWARD P. RADFORD, JR., M.D.; H. LOUIS MCCOMBS, M.D.; and VILMA R. HUNT, B.D.S.
The New England Journal of Medicine, December 16, 1965.

Though the Po^{210} concentration in bronchial wall was similar to that present in lung parenchyma, it was about two orders of magnitude greater in bronchial epithelium than in parenchyma or lymph nodes. By far the highest concentrations were found in epithelium from segmental bifurcations where levels as high as 13.9 picocurie per gram were measured.

Measurable Po^{210} was also present in superficial mucus from all smokers. The concentrations ranged from 0.002 to 0.044 picocurie per gram of mucus, except in one case in which the concentration was much higher.

No correlation existed between number of cigarettes smoked, or time since the last cigarette, and the Po^{210} levels in bronchial epithelium. Similarly, there was no correlation between parenchymal and epithelial concentrations. In the two pipe smokers epithelial Po^{210} content was similar to that of cigarette smokers though the parenchymal concentrations were very low. Significant, though low, levels of activity were found in the lobar bronchus and one bifurcation of the single past smoker.

Mode of Entry

"Unsupported" Po^{210}, or polonium not present with its long-lived parent, $lead^{210}$, may be taken into the body directly. Because its half-life is only 138 days, exposure to the isotope would have to be fairly continuous for a steady-state concentration to be reached in tissues. On the basis of preliminary measurements of lead, we believe that most of the Po^{210} in smokers' lungs comes from such unsupported Po^{210} present in cigarette smoke.

The relatively low Po^{210} concentration in lung parenchyma of cigarette smokers as compared to nonsmokers suggests that the majority of inhaled smoke particles is rapidly cleared from the lung. The distribution of polonium activity in the lung parenchyma of cigarette smokers suggests that either deposition or clearance of smoke is not uniform. Because deposition of cigarette smoke depends on diffusion, it should be relatively uniform within the lung. The lower polonium content in peripheral parenchyma probably reflects a more rapid clearance of smoke from peripheral lung tissue into the bronchial tree than from more central regions. Clearance of the majority of inhaled cigarette-smoke particles appears to be rapid and to occur primarily by way of the bronchi.

Not Only Factor

It is unlikely that alpha radiation is the sole factor responsible for bronchial tumors in smokers. Other agents in cigarette smoke may well contribute significantly as cocarcinogens, and the effect of a small radiation dose may be considerably magnified by their action.

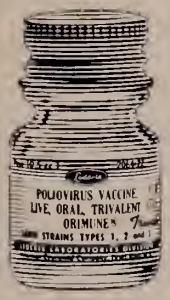
Because of the uncertainty associated with dose estimates to bronchial stem cells in cigarette smokers, it is premature to assert that Po^{210} is or is not likely to be the major factor in induction of bronchial cancer in smokers. It is unlikely that there is a threshold dose below which no effect would be produced by alpha radiation; on this basis any dose, no matter how small, would have a certain probability for tumor induction. Finally, recent preliminary studies in animals indicate that alpha radiation may be a much more potent carcinogen in the production of certain skin cancers than more sparsely ionizing radiation.

As for the distribution of Po^{210} within the lung, the high levels found in segmental bifurcations are in regions where bronchial carcinomas frequently arise. The relatively low concentrations in lung parenchyma indicate that significant localization does not occur in the alveoli and, indeed, parenchymal tumors are relatively uncommon in cigarette smokers.

On the basis of the available evidence, it may be concluded that radiation from Po^{210} may be an important factor in the initiation of bronchial cancer in cigarette smokers.

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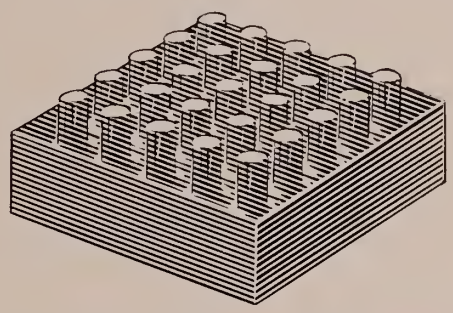


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*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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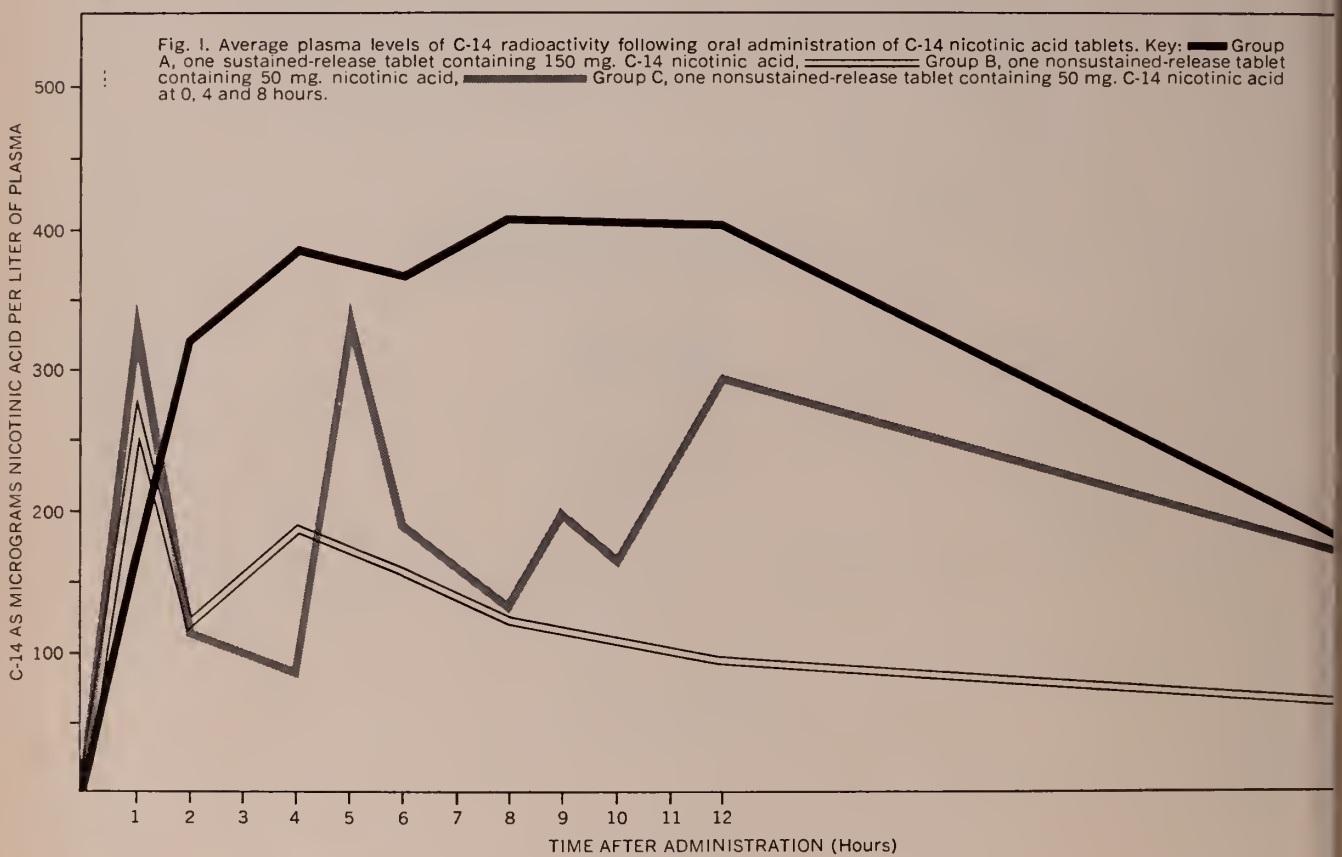
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Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be co-tinuous on a daily dose of only one Geroniazol TT ta-let every 12 hours.

The gradual release of nicotinic acid in Geronia l TT will provide the well-known peripheral vasodila-tion needed in patients with deficient circulation a with a minimum amount (if any) of "flushing." Al cerebrovascular circulation is complemented by p tylenetetrazol, long-established as a cerebral and r piratory stimulant.

Geroniazol TT improves the typical, unfortuna signs of senile confusion. Patients become more ale

ted and debilitated

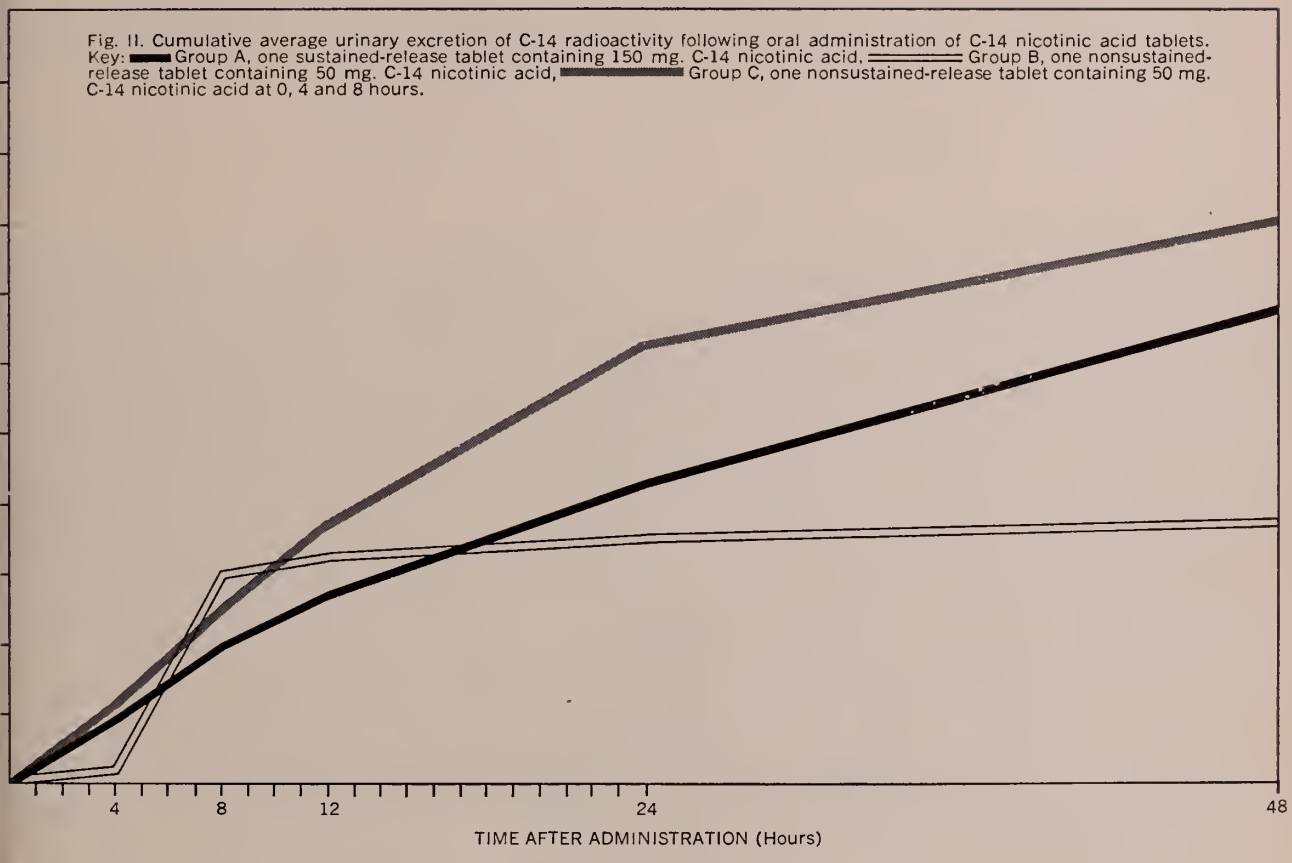


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

s confused and moody. Personal care, memory, otional stability, social attention improve. Fatigue, thy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will mit your patients to enjoy the benefits of time-longed nicotinic acid/pentylenetetrazol therapy, n economical price. Dosage is only one tablet every hours.

ntraindications: There are no known contraindica-ns.

ecautions: Exercise caution when treating patients h a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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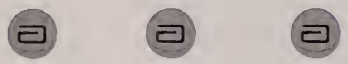
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Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

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The other force . . . Medicare . . . may prove even more potent. Consider the impact on Blue Shield when the Medicare Part B carrier decides that the reasonable charge for a particular service rendered to a Medicare patient is $200, while the Blue Shield allowance for the same service is $150 . . . despite the fact that the Medicare patient's income may be only $3,000, whereas the Blue Shield patient has a family income of $7,500 and is entitled to service benefits from a Participating Physician.

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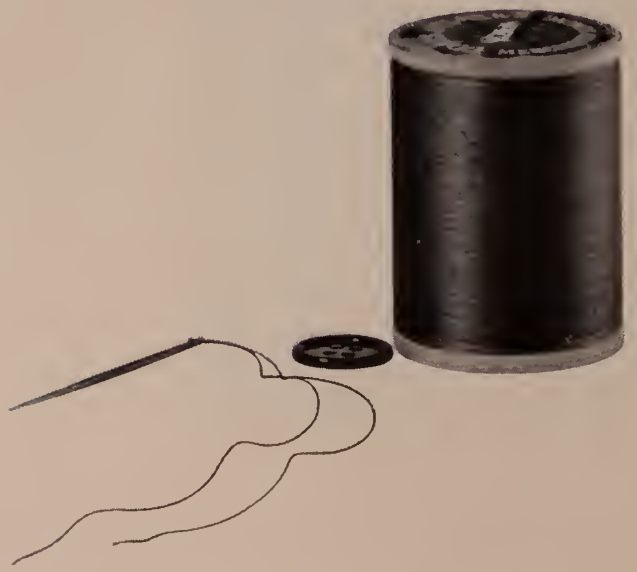
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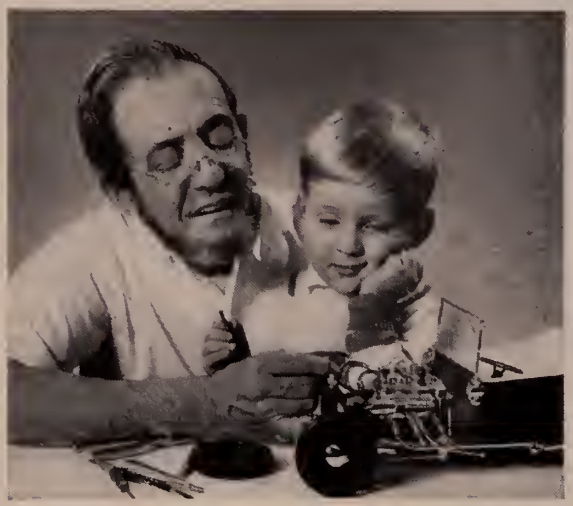
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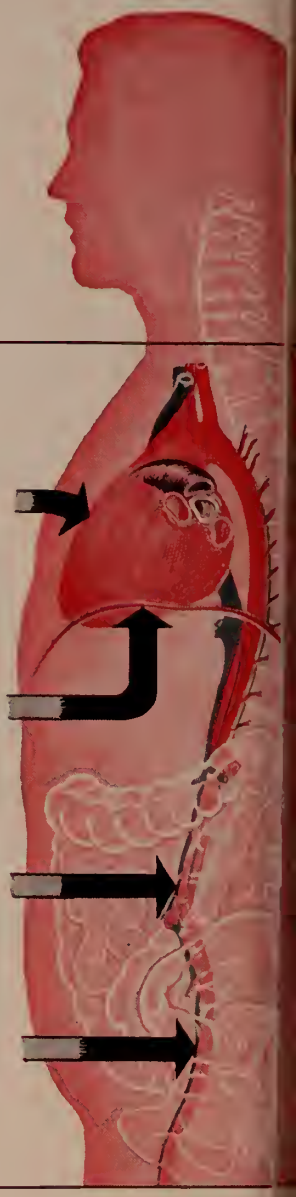
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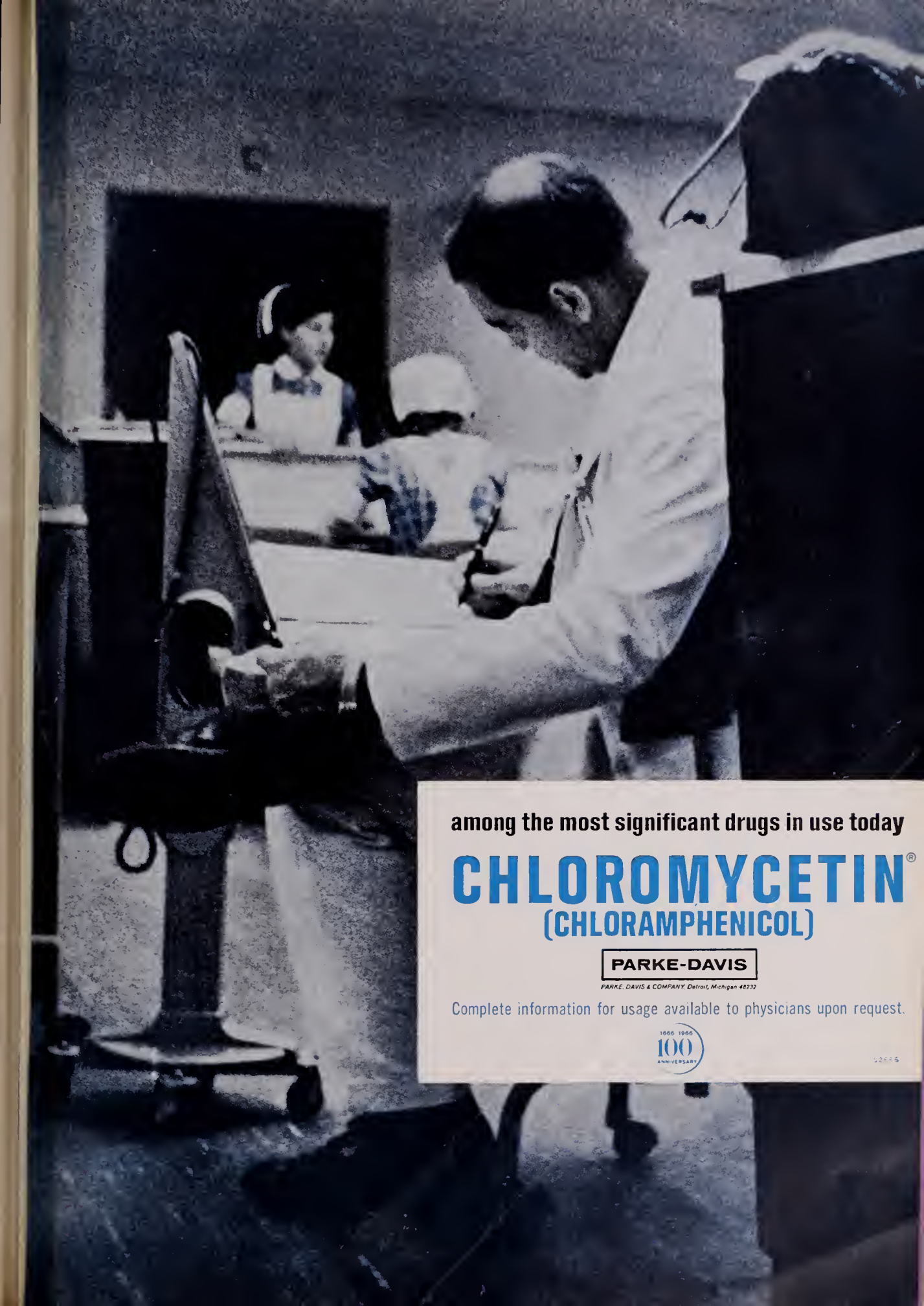
The 1966-67 edition of the Membership Directory of The Medical Society of New Jersey will be sent to all members in good standing in mid September 1966. It will feature a biographical entry for each member, including name, address, telephone number, office hours, year of birth, medical school, year of graduation, New Jersey license number, type of practice, Board certification, fellowship(s), professional organizations, hospital staff appointments, and type of membership in MSNJ and AMA. . . in the order enumerated.

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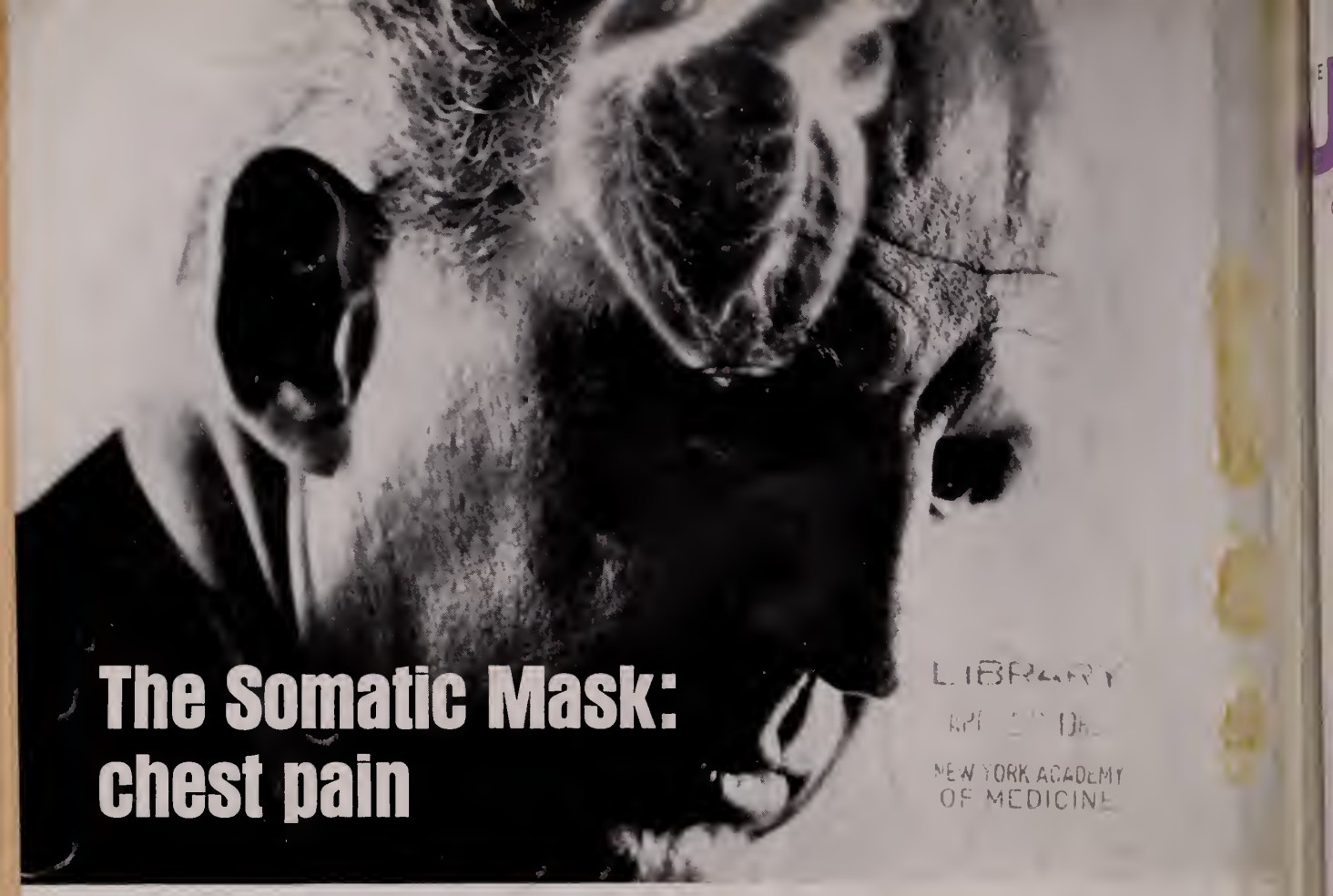
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CONTENTS • Pages 153 to 184

EDITORIALS
The Denigration of Charity 153
Don't Laugh Off the Insect Bite 153
Animal Crackers 154

ORIGINAL ARTICLES
Betamethasone In Arthritis and Bursitis
Keith E. Haines, M.D., Camden 155
Congenital Dextrocardia and Situs Inversus Totalis
Annop Intharakoses, M.D., Trenton 159
Griseofulvin and Lupus Erythematosus
William A. Anderson, M.D. and Douglas Torre, M.D., Orange 161
Choledochal Cyst Simulating Biliary Atresia
Alfred J. Spiro, M.D., Philadelphia, Pa. 163
Giant Condylomata Accuminata Associated with Carcinoma
Austin S. Litvak, M.D., Irving Melnick, M.D. and Paul R. Lieberman, M.D., Long Branch 165
Solid Carbon Dioxide Therapy in Dermatology
Sam C. Atkinson, M.D., Summit 168

STATE ACTIVITIES
Trustees' Minutes: March 20, 1966 171
February 20, 1966 174
Good Form for Medicare 176
"Pap" Smear Kits 176
Bicentennial Souvenirs 41A
Membership Directory 42A

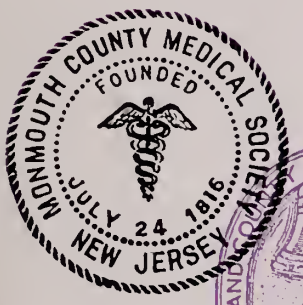
BICENTENNALIA 179

OBITUARIES 180

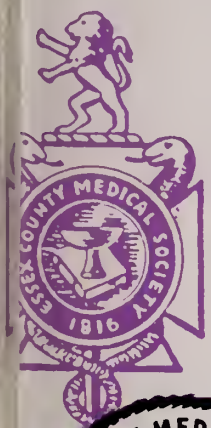
BOOK REVIEWS 181

RESPIRATORY DISEASE ABSTRACTS 183

May, 1966 • Vol. 63, No. 5
200th ANNIVERSARY MEETING
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ON THE COVER

In its bicentennial year, the official seal of The Medical Society of New Jersey shares prominence with the official seals of those component societies celebrating their sesquicentennial anniversaries. According to the proceedings of the New Jersey Historical Society ("An Outline of the History of the Medical Society of New Jersey to 1900"), the first county medical societies organized in 1816 were: Somerset, May 21; Essex, June 4; Cumberland, June 6; Middlesex and Morris, June 11; and Monmouth, July 24.



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'Aerosporin'® brand Polymyxin B Sulfate ..... 5,000 Units

Zinc Bacitracin ..... 400 Units

Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base) ..... 5 mg.

Tubes of ½ oz. and 1 oz.

- clinically effective
- comprehensive bactericidal action against most Gram-negative and Gram-positive organisms, including Pseudomonas
- rarely sensitizes

For the eradication of infectious organisms in a wide range of dermatologic disorders: impetigo, ecthyma, pyodermas, sycosis vulgaris, paronychia, traumatic lesions, eczema, herpes and seborrheic dermatitis. Prophylactically, for protection against bacterial contamination in burns, skin grafts, incisions and other clean lesions, abrasions and minor cuts and wounds.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Contraindication: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

...but doctor, I eat like a bird!



IN WEIGHT CONTROL

OBETROL®

Each OBETROL-10 tablet contains: Methamphetamine Saccharate; 2.5 mg. Methamphetamine Hydrochloride; 2.5 mg. Amphetamine Sulfate; 2.5 mg. Dextro-amphetamine Sulfate; 2.5 mg. (OBETROL-20 tablets contain twice this potency) Pat. #2748052.

This combination of amphetamines may be useful as an adjunct in the management of certain forms of obesity where an appetite depressant is indicated.

CONTRAINDICATIONS: Hypertension, advanced arteriosclerosis, coronary artery disease, cardiac arrhythmias, peripheral vascular disease, states of undue restlessness, anxiety, excitement, agitated depression, hyperthyroidism, idiosyncrasy to amphetamine, concomitant administration of a monoamine oxidase inhibitor. PRECAUTIONS: Use with caution in individuals with anorexia, insomnia, vasomotor instability, asthenia, psychopathic personality, a history of homicidal or suicidal tendencies, and individuals who are known to be hyperreactive to sympathomimetic agents, or emotionally unstable individuals who are known to be susceptible to drug abuse. Certain monoamine oxidase inhibitors may potentiate the action of Obetrol. SIDE EFFECTS: The most common side effects attended with the use of amphetamines include nervousness, excitability, euphoria, insomnia, dryness of mouth, nausea, vertigo, constipation, and headache. DOSAGE AND ADMINISTRATION: Initial adult dose is one-half to one 'Obetrol-10' tablet daily, preferably one-half to one hour before meals. This may be gradually increased to one 'Obetrol-10' or 'Obetrol-20' tablet one to three times daily as indicated. SUPPLIED: Tablets scored, in bottles of 100, 500, and 1000.

REQUEST SAMPLES AND LITERATURE

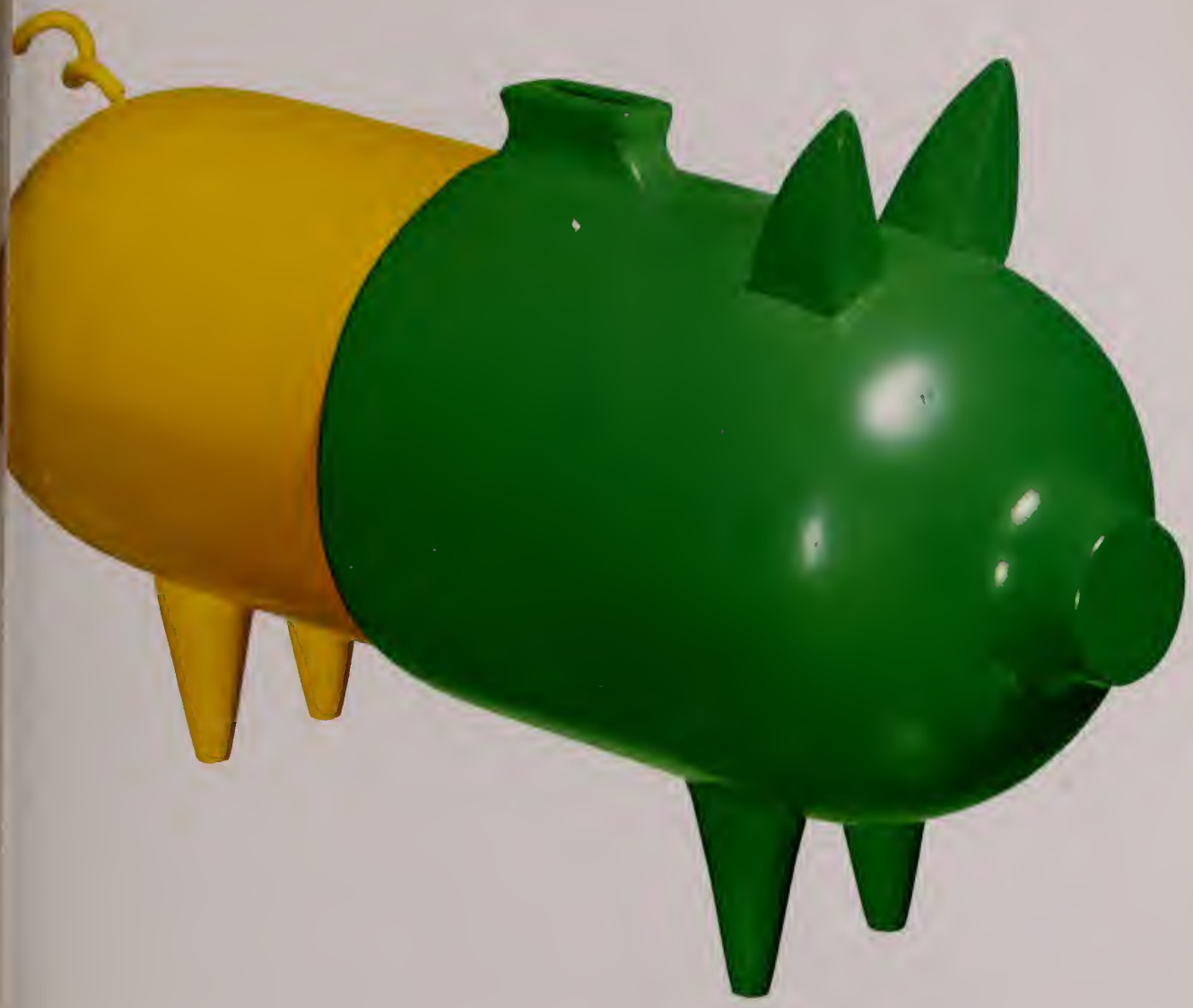
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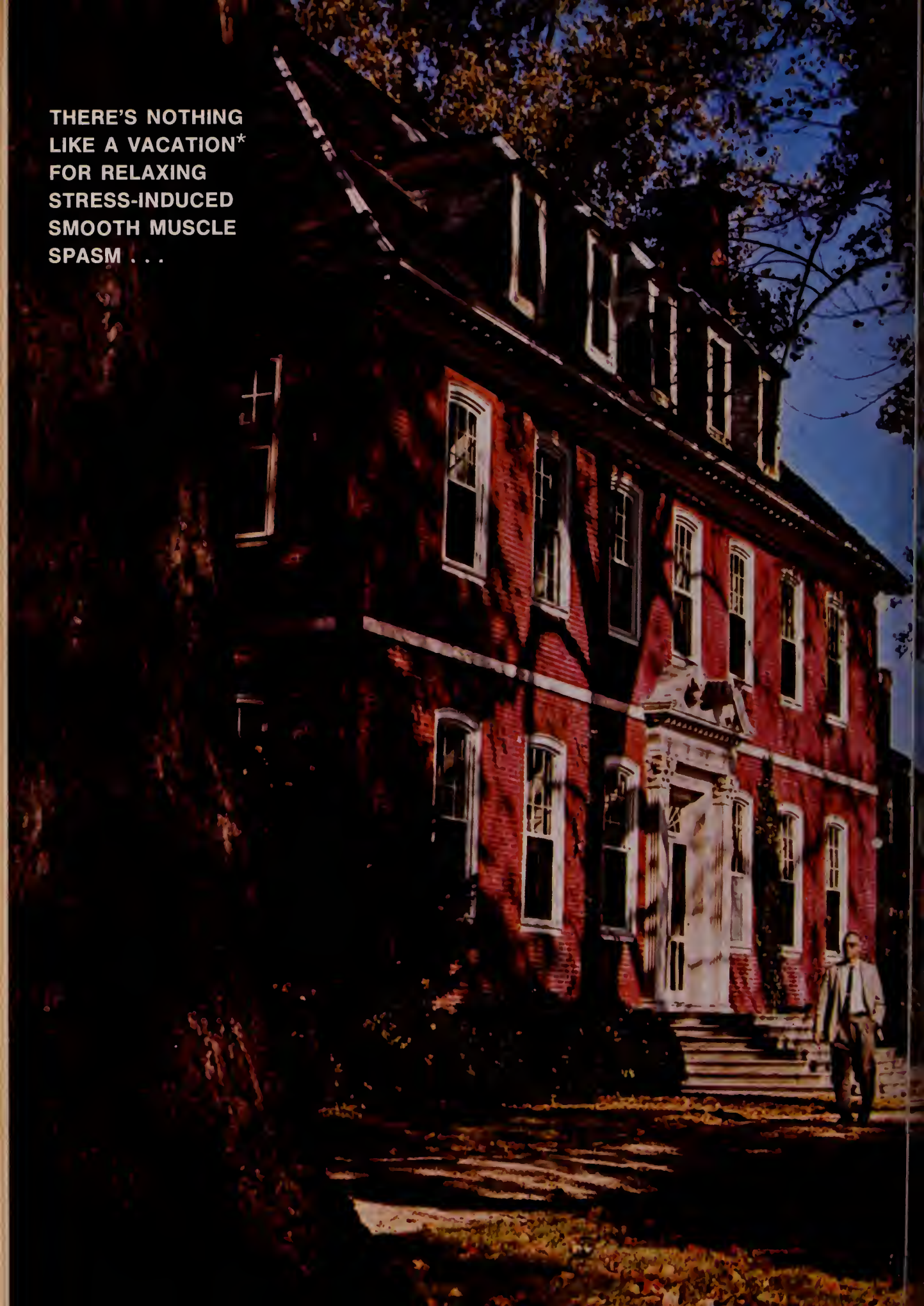
When you prescribe or recommend Allbee with C, you can be sure your patient is getting a rational, specific multivitamin formulation at an economical price. The potent formula is sensible and simple. It contains therapeutic amounts of the water-soluble B and C vitamins. These vitamins are expended rapidly in the body and need to be replenished frequently. There are no extraneous factors, no frills in Allbee with C. It's the no-nonsense vitamin in the yellow and green capsule that always gives your patient his money's worth.

Each capsule contains: Thiamine mononitrate (B_1), 15 mg.; Riboflavin (B_2), 10 mg.; Pyridoxine hydrochloride (B_6), 5 mg.; Nicotinamide, 50 mg.; Calcium pantothenate, 10 mg.; Ascorbic acid (vitamin C), 300 mg.

A. H. ROBINS COMPANY, INC.,
RICHMOND, VIRGINIA 23220 A·H·ROBINS

—a good reason for AHR

ALLBEE® WITH C


THERE'S NOTHING
LIKE A VACATION*
FOR RELAXING
STRESS-INDUCED
SMOOTH MUSCLE
SPASM . . .

. . NOTHING, THAT IS,
EXCEPT THE SEDATIVE-ANTISPASMODIC
BENEFITS OF

DONNATAL®

There's nothing quite like a vacation to ease the pressures of the modern, "workingday" world. And for the patient who can't get away from it all, there's nothing quite like Donnatal to relax stress-induced smooth muscle spasm. For 31 years it has been the antispasmodic-sedative most often prescribed for relieving functional disturbances of tone and motility of the gastrointestinal tract.

belladonna alkaloids in optimally balanced ratio

In Donnatal, natural belladonna alkaloids are rationally balanced in a specific, fixed ratio that provides "the greatest efficacy with the smallest possible dose."[1] They avoid the clinical uncertainties of the variable tincture and extract of belladonna, and are considered superior in range of action to atropine alone.[2] Furthermore, they are generally recognized as being more effective than the synthetics for relieving visceral spasm.

phenobarbital for sedation

Years of clinical use have established phenobarbital as one of the most efficient and highly regarded sedatives. In fact, for general sedation it is the drug of choice.[3] In Donnatal, phenobarbital potentiates the spasmolytic effects of the belladonna alkaloids, lessening emotional tensions and checking the neurogenic impulses that trigger GI disorders.

more than 24 indications in PDR

Donnatal has withstood the test of time to become the classic sedative-antispasmodic because of its unsurpassed effectiveness, safety, economy, uniformity of composition, and dosage convenience. Its widespread acceptance and usage by the profession can also be attributed to its versatility in treating disorders characterized by smooth muscle spasm. There are more than two dozen distinct and separate indications for Donnatal listed in the current PDR.

IN EACH TABLET, CAPSULE, OR (5 cc.) OF ELIXIR

hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide	0.0065 mg.
phenobarbital	(1/4 gr.) 16.2 mg.

(warning: may be habit forming)

IN EACH EXTENTAB

hyoscyamine sulfate	0.3111 mg.
atropine sulfate	0.0582 mg.
hyoscine hydrobromide	0.0195 mg.
phenobarbital	(3/4 gr.) 48.6 mg.

(warning: may be habit forming)

BRIEF SUMMARY: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma, or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease, or a hypersensitivity to any of the ingredients.

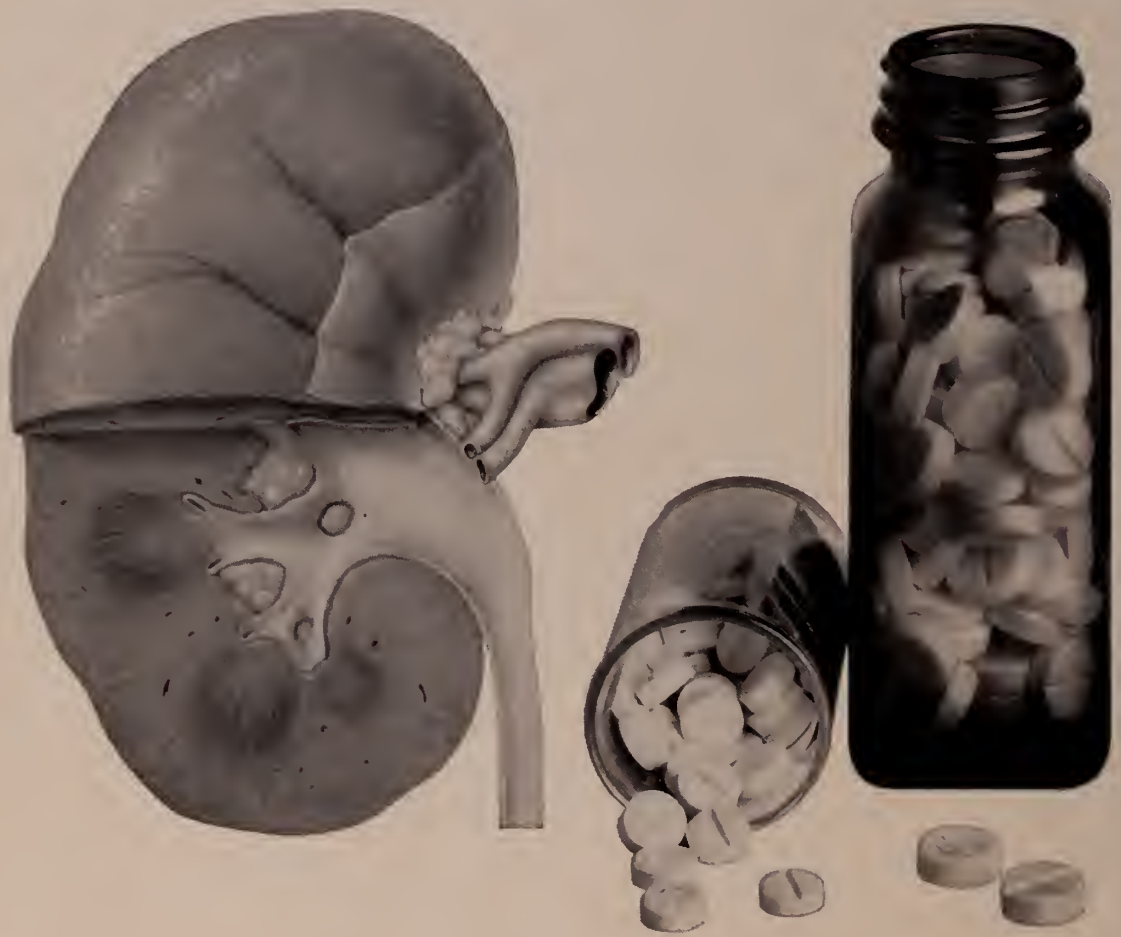
REFERENCES: 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

*This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

A. H. ROBINS COMPANY, INC., RICHMOND, VA.

A·H·ROBINS

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

An antibiotic of choice is one that works

TAO works

Susceptibility Results
Staphylococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
6,725	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

The Product

In a world study of antibiotics *in vitro*[1], TAO had an overall effectiveness of 87.3%, higher than chloramphenicol and erythromycin, and significantly higher than tetracycline and penicillin.

The Plus... Consistent Performance

Yet antibiotics must not only work. They must work consistently. Here are the results from the largest study of microbial susceptibility ever undertaken. In 29,048 cultures of overt staphylococcal and β-hemolytic streptococcal infections, note the consistency of results with TAO.

TAO®
[triacetyloleandomycin]

J. B. Roerig and Company, New York, New York 10017
Division, Chas. Pfizer & Co., Inc., Science for the World's Well-Being®

TAO Rx information

Indications: The bacterial spectrum includes: streptococci, staphylocci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **Contraindications and Precautions:** TAO (triacetyloleandomycin) is not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents, of course, should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. It is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. **References:** 1. Isenberg, Henry D.: Health Laboratory Science **2**:163-173 (July) 1965. 2. Fowler, J. Ralph et al: Clinical Medicine **70**:547 (Mar.) 1963. 3. Isenberg, Henry D.: Health Laboratory Science **1**:185-256 (July-Aug.) 1964.

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A savings account in the Orange Savings Bank is one of the safest non-fluctuating investments a person can make.

The current interest rate on savings is 4%—payable and compounded quarterly. Payable from the first day of deposit. (There is no waiting period!)

We have a record of uninterrupted dividend payments over the past 111 years.

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Annual Meeting

Saturday-Wednesday

May 14-18, 1966

Haddon Hall, Atlantic City

PLAN TO ATTEND

Bamadex® Sequels®

Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



First aid for a button popper



Second aid for a button popper

Bamadex® Sequels®

d-amphetamine sulfate (15 mg.) and meprobamate (300 mg.)

Sustained Release Capsules

By providing combined anorexigenic-tranquilizing action, BAMADEX SEQUELS Capsules help your nonshrinking patients to establish new patterns of eating less. The amphetamine component suppresses the appetite, while the meprobamate helps allay nervousness and tension. And for most patients, the *sustained* release of the active ingredients makes possible convenient one-capsule-a-day dosage.

LEDERLE LABORATORIES · A Division of American Cyanamid Company, Pearl River, New York

Lederle

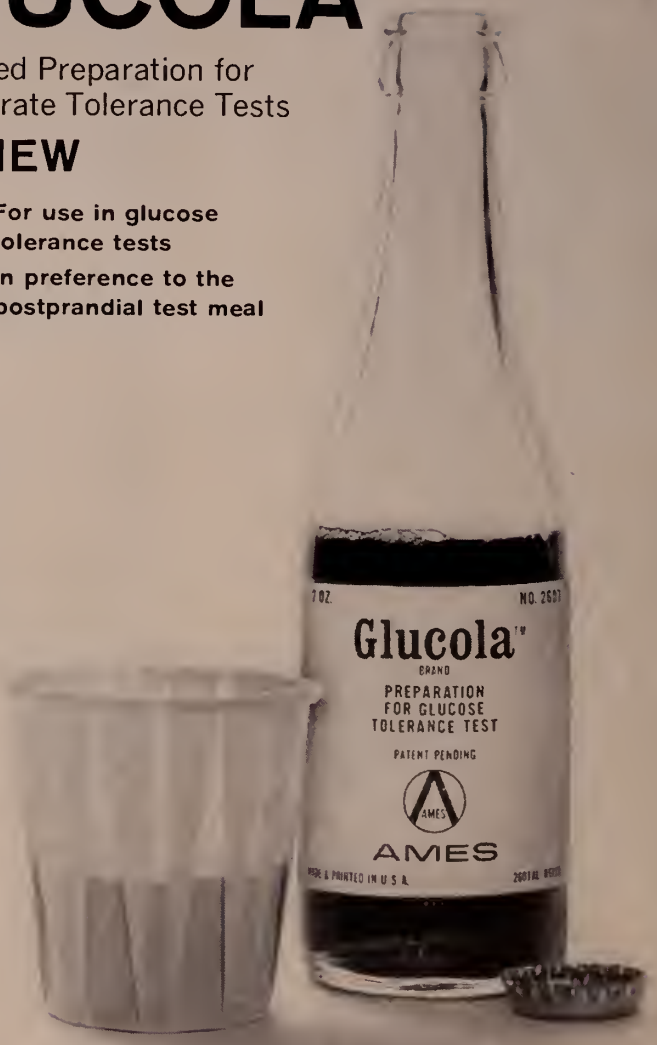
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Carbonated Preparation for
Carbohydrate Tolerance Tests

NEW

- **For use in glucose tolerance tests**
- **In preference to the postprandial test meal**



A NEW SOLUTION FOR AN OLD PROBLEM

Ready to use • Pleasant tasting cola flavor • Well tolerated

A 7-ounce bottle of GLUCOLA provides a liquid oral loading dose equivalent to 75 Gm. of glucose* for carbohydrate tolerance testing. GLUCOLA avoids the nausea that frequently results from lingering sweet laboratory preparations, and the occasional emesis that necessitates rescheduling the test. With GLUCOLA, no time is lost weighing and mixing glucose "cocktails"—only a bottle opener is needed.

753(R2)64

*The rapidly hydrolyzable saccharides in this formulation assure optimum absorption and glucose levels comparable to those obtained with a 100 Gm. loading dose.

Available through your regular supplier:
cartons of 12 7-oz bottles (6 bottles per pack, 2 packs per carton).

Ames Company, Inc.
Elkhart, Indiana

AMES



the sedentary life is often the seat of low back pain

The human spine is not engineered fo prolonged sitting at desks, pianos, type writers and drafting boards. The stresses set up by the heavy, forward-tilted heac and trunk, balanced precariously on ar insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and anal gesic properties of 'Soma' make it espe cially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management o muscle spasm, pain, and stiffness in a variety o inflammatory, traumatic, and degenerative muscu loskeletal conditions. It also may act to normaliz motor activity in certain neurologic disturbances

Contraindications: Allergic or idiosyncratic reac tions to carisoprodol.

Precautions: 'Soma', like other central nervou system depressants, should be used with caution in patients with known propensity for taking ex cessive quantities of drugs and in patients with known sensitivity to compounds of similar chemi cal structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness ataxia, tremor, agitation, irritability, headache, in crease in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leuko penia, occurring when carisoprodol was admin istered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablet and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

SOMA
(CARISOPRODOL

Wallace Laboratories, Cranbury, N.J.

26S01



ON BEHALF OF 2,644,347 NEW JERSEY RESIDENTS — A HEARTFELT

"Happy Anniversary!"

• The Blue Shield "family" of more than 2.5 million members extends congratulations to the Medical Society of New Jersey for 200 years of humanitarian service to the people of the state . . . together with deep gratitude for having made possible, through Blue Shield, their protection against financial inroads caused by illness and accident.

• The Board of Trustees and Administration of Blue Shield also take this occasion to gratefully acknowledge the guidance, counsel and support of the Society which has enabled the Plan to fulfill its mission of service to the New Jersey community for nearly a quarter-century . . . and to reaffirm the Plan's dedication to performance of that mission, in partnership with the Society, for the years to come.

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MEDICAL-SURGICAL PLAN
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Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.



mood elevation

Abbott
Anorectic
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DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.



controlled release

Abbott
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Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

Abbott
Anorectic
Program

DESOXYN Gradumet
Methamphetamine Hydrochloride in Long-Release Dose Form



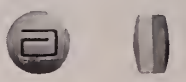
5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



Front Side

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium



Front Side

samples available



Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.



economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

ABBOTT

Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
Sucaryl—Abbott brand of low and non-caloric sweeteners.

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IMPORTANT FACTS

about

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Our policy, approved and recommended by The Medical Society of New Jersey is broad enough to cover:

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(2) The financial loss to a physician in attending trial as a defendant in protracted litigation.

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in any language

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As a first step:

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SERPATE® (Reserpine) is modestly priced

SERPATE® (Reserpine) in low oral dosage is characterized by a minimum of serious reactions and low-yield side effects—thus, it may be used with comparative assurance

SERPATE®(Reserpine) combines readily with more potent antihypertensives for patients exhibiting severe hypertension

Physician samples and technical data sent on request

(Supplied in doses of 0.1 mg. white tablets and 0.25 mg. yellow tablets)

VALE

THE VALE CHEMICAL CO., INC.
PHARMACEUTICALS • ALLENTOWN, PENNSYLVANIA

INDICATIONS: moderate hypertension; labile hypertension, particularly when accompanied by tachycardia or neurosis; and as adjunctive therapy to the more powerful hypotensive drugs in severe hypertension.

DOSAGE: The initial dosage of SERPATE® (reserpine) is 0.5 mg. to 1.0 mg. in divided doses daily. Initial dosage should not be continued more than one week. After one week, the recommended daily dosage is 0.1 mg. to 0.25 mg. An occasional patient will require a maintenance dose of 0.5 mg., but if adequate response is not obtained from this dosage it is well to consider adding another hypotensive agent rather than increase the dosage. Reserpine action is cumulative and maximum response may not be observed until several days to two weeks elapse after therapy is initiated. Slight residual effects may persist for several weeks after discontinuation of therapy. Important: Use SERPATE® (reserpine) with caution in patients with history of mental depression, peptic ulcer, or ulcerative colitis. Members of patient's family should be alerted to watch for and report any symptoms of mental depression.

WARNING: Anesthetics have been found to increase the hypotensive effect of reserpine. Caution should be taken to withdraw patients from SERPATE® (reserpine) two weeks prior to administering anesthetics or to elective surgery. Use with caution in gravid patients. Reserpine passes the placental barrier and may affect the newborn.



ıtazolidin® alka

ıutazone	100 mg.
uminum de gel	100 mg.
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opine bromide	1.25 mg.

In rheumatoid arthritis—effective therapy with minimal chance of G-I upset

e peutic Effects
o 75% of patients obtain major relief of ic symptoms, as reported by numer- inicians. In addition, the problem of c upset—a major problem with certain oral antiarthritic agents—is minimized presence of antacids and an antispas- in the formulation.

ovement is generally seen within 3 to 4 and trial therapy need not be con- d beyond a week. Relief of pain is ved quickly by resolution of inflamma- nd improved joint function. Relief of toms is often accompanied by in- ed appetite, gain in weight and an oved sense of well-being.

nitial response is usually maintained ut dosage increases; indeed, initial ge is often reduced for maintenance oses.

ylate or steroid therapy can usually be nished or, in some instances, eliminated.

raindications
na; danger of cardiac decompensation; ry or symptoms of peptic ulcer; renal, tic or cardiac damage; history of drug gy; history of blood dyscrasia. Because e increased possibility of toxic reac- , the drug should not be given when the nt is senile or when other potent notherapeutic agents are given concur- rently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage in Rheumatoid Arthritis
Initial: 3 to 6 capsules daily in divided doses. It is usually unnecessary to exceed 4 capsules daily. A trial period of 1 week is adequate to determine response; in the absence of favorable response, discontinue.

Maintenance: An effective level is often achieved with 1 to 2 capsules daily; do not exceed 4 daily.

Also available:
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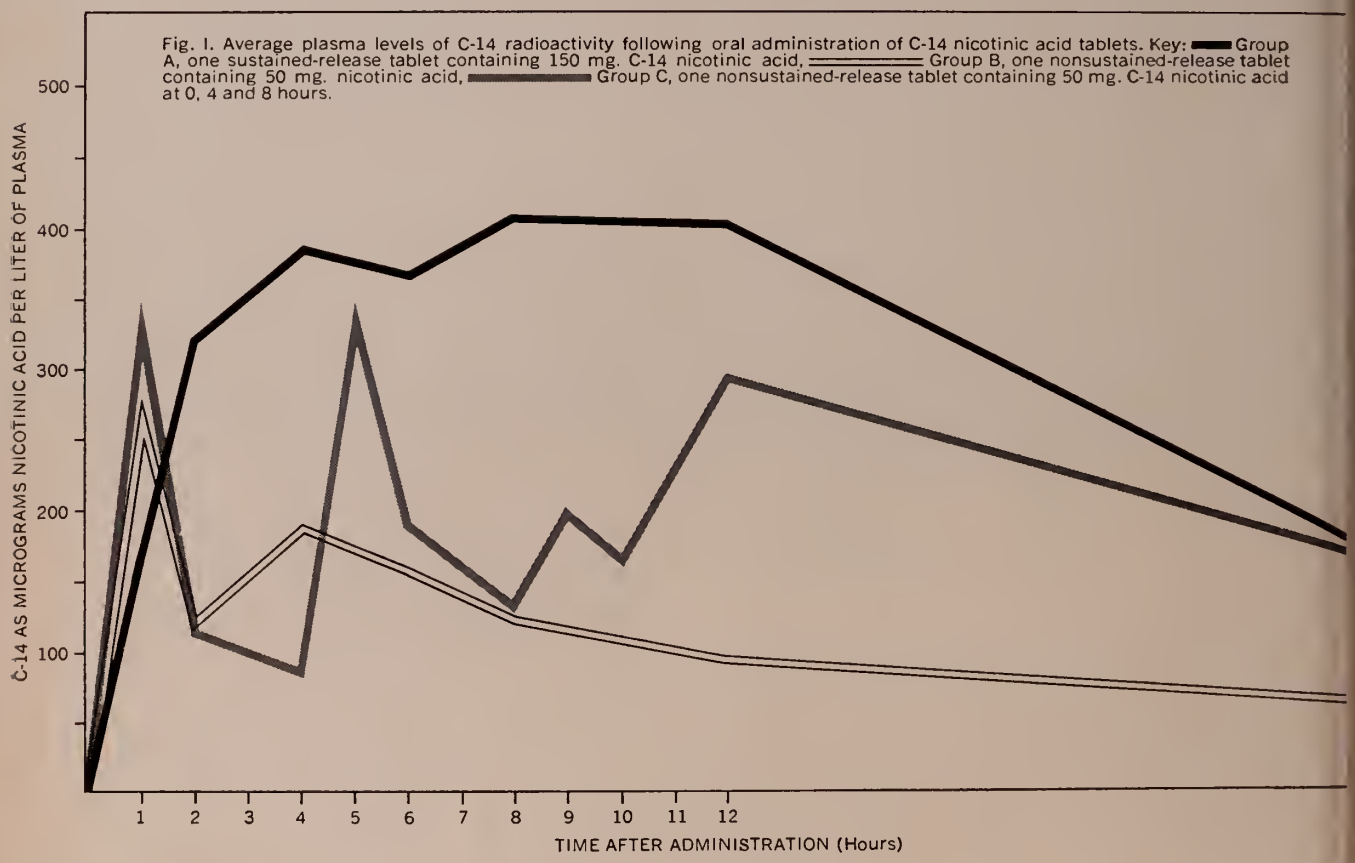
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Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be co tinuous on a daily dose of only one Geroniazol TT ta let every 12 hours.

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Geroniazol TT improves the typical, unfortunat signs of senile confusion. Patients become more ale

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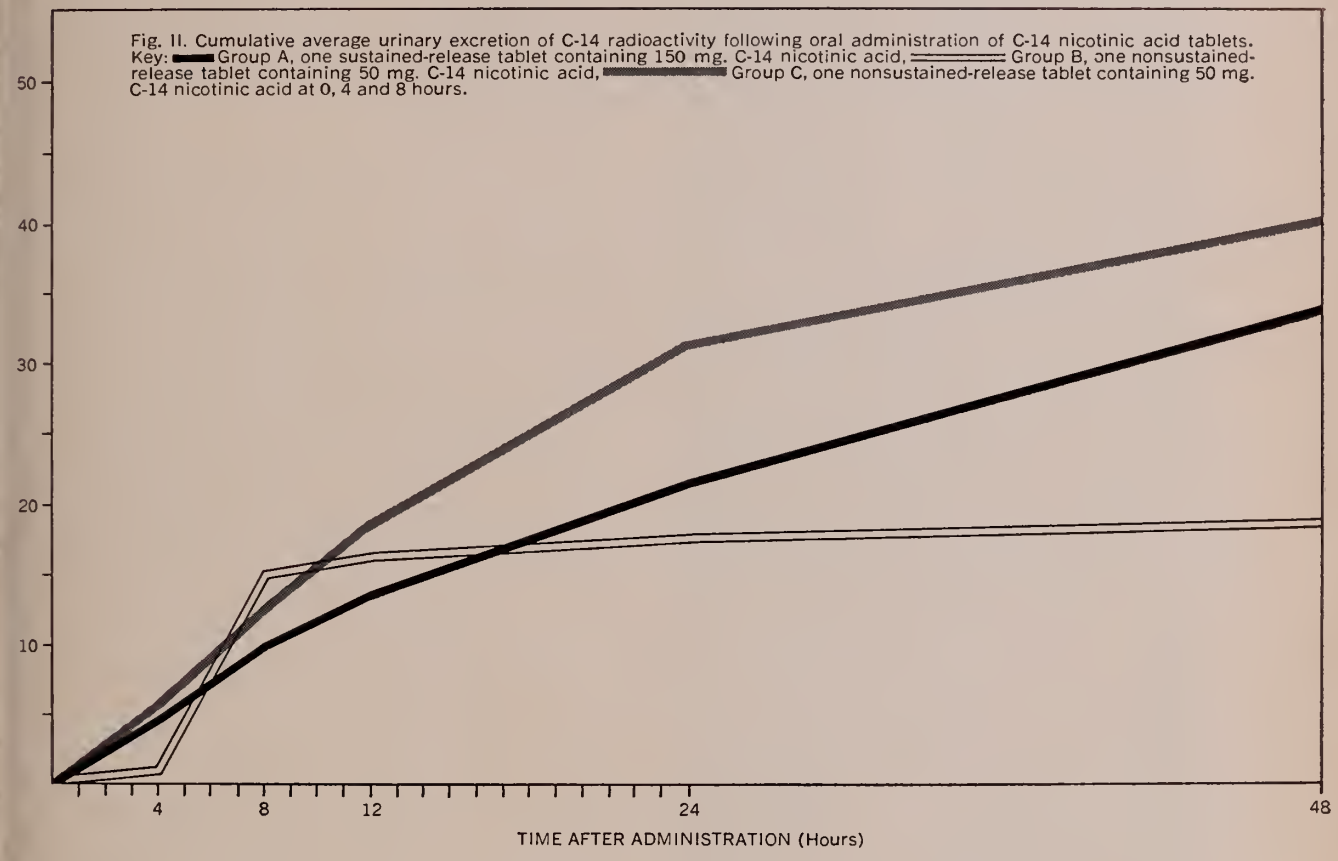


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

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Dosage: One tablet every 12 hours.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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EDITORIALS

The Denigration Of Charity

Charity—from the Latin *cara* ("dear")—originally meant the love of man for his fellow man. By the sixteenth century it had narrowed to the sense of "caring about the poor"; by the 19th century the word had become institutionalized—and a Charity, with a capital C, was thought of as an organization. And by the early 20th century the word had acquired its patronizing flavor. And so, by now, "charity" has overtones of self-congratulation for the patron and contempt for the recipient. If a doctor speaks of "charity cases" or of devoting time "to charity," he is suspected of telling the public to "see what a good man I am." Some of the contempt felt for charity recipients is reflected in an article by Prinzmetal* who calls his column "The Humane Treatment of Charity Patients." He says that during his medical school and residency days, he was often "horrified by the inhumane manner in which charity patients were treated." And he describes repulsive examples of callousness and unconcern for a patient's feeling and privacy that suggest he must have been talking about 19th century practice. But Prinzmetal got his M.D. in 1933 which, if it was during the great depression, was still in our time. It is, perhaps, significant that the author does not put the word "charity" in quotations. He sees no need to apologize for the word or the practice.

If the word was acceptable to the 1933 graduate, it seems to be an uncomfortable one for the medical graduate in the sixties. And, perhaps, in our very discomfort about the word is a hope for the future. If we could return the meaning to its medieval one (divine and human love of man) it would be fine. But so long as it carries the connotation of our nobly patronizing the unfortunate and asking credit for being so generous, it is perhaps just as well that we put quotation marks around it. But it might be good for us to remember that once the word had a broader meaning: and that the greatest of these was charity.

Don't Laugh Off The Insect Bite

Stinging insects are attracted by hair sprays perfumes, tonics, sun tan lotions, and other cosmetics. They fly towards bright colors, flowery prints, and black.

Bees may build a nest in a log. Kicking a dead log can dislodge a mob of angry bees.

Persons with known sensitivity, small children, and those who have been stung several times need swift medical attention. If your patient is known to have sensitivity, you should advise him about developing immunity. This might save lives. Since the treatment takes some time, start it in the fall or winter to protect your patient during the following spring and summer.

The family should be reminded that if they decide to paint the house, spruce up the garden, or clean the garage, they might stir up insects. They must be told that wasps and hornets build nests in or under eaves, behind shutters, around chimneys, on the exteriors of garages, under carport roofs, in woodpiles, and other protected places. The unwary painter could be in for severe attack if he inadvertently disturbs a nest. The wise man looks for them first and dislodges them with a long pole, making sure he can get away quickly. Subsequent, careful use of an insecticide will dispose of the wasps.

Yellow jackets have nests in the ground. A barefoot child who unwittingly disturbs one could be in for a bad time. A thoughtful parent will examine his premises for evidence of yellow jackets before allowing a child to go barefoot.

* Prinzmetal, Myron: In the September 22, 1965, *Medical Tribune*, New York City.

To the householder, the sophisticated physician can give advice like this: if the nest of a yellow jacket is located, mark it with a twig. In the early evening, when the yellow jackets have returned to the nest, they can be disposed of by pouring gasoline or kerosene in the hole. Don't use water and a hose. The insect may attack the user.

The New Jersey Allergy Society recommends that persons strongly allergic to insect stings obtain a Medic Alert emblem from the Medic Alert Foundation, Turlock, California 95380. These small metal disks can be worn as bracelets, with a notation that the wearer faces a specific special risk, one of them being "allergic to bee stings." This Foundation maintains a file of its members, the nature of the special risk, addresses of physicians and relatives, and other useful data.*

Animal Crackers

Back in 1918 when the bovine tuberculosis program started, 5 per cent of the cows reacted positively. Today, after an intensive program, only 0.1 per cent react positively.[1] How about humans? Well, last year more than 10,000 Americans died of tuberculosis, and now 20 per cent of the USA human population are positive reactors to tuberculin.[2] Last year, more than 50,000 new cases of *active* pulmonary tuberculosis developed in our country— and each became a focus for potential distribution of the mycobacterium to others.[3]

Conclusion: We take more trouble preventing tuberculosis in cows than we do to preventing it in human beings.

Recent hearings about patient care at Greystone Park indicate that attendants start at salaries of $3,500 a year without maintenance. Keepers in large government zoos start at some $4,400 a year.

Conclusion: We pay people more for taking care of animals than we do for care of human beings.

Without experimental, diagnostic, and research animals we could never have developed diphtheria antitoxin, small-pox vaccine, cardiac surgery, and so on. But all sorts of road blocks are thrown in the way of acquiring laboratory animals and working with them for human research.

Conclusion: We love the animals more than we love the children whose lives might be saved (and with diphtheria antitoxin, whose lives *were* saved) by animal experimentation and research.

In terms of rates per hundred thousand population, the syphilis (primary and secondary, first reported cases) rate[4] was 4 back in 1957. The figure had sky-rocketted from 4 to 10 by 1962![5] But the U.S. Government's budget for venereal disease control was cut in a few years from 17 to 3 million dollars.[6]

But if the syphilis rate went up, at least we managed to reduce the incidence of rabies in dogs. Prior to 1960, the number of new rabies cases in dogs averaged about 6,000 a year. But by intensive work, our public health people got the figure down to 400 new cases last year.[7] The dogs did pretty well. As St. Bernard (for whom one was named) said, *"Qui me amat, amat canem meum."*[8]

Conclusion: "A righteous man" (to quote Proverbs[9]) "regardeth the life of his beast."

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* Material in this editorial is drawn from a recent release of the New Jersey State Health Department, from a brochure on insect bites, prepared by the Allergy Foundation (selling at 10¢ and available from the Allergy Foundation at 801 Second Avenue, New York 10017), and from a report of the New Jersey Allergy Society.

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ORIGINAL ARTICLES

Direct intra-articular and intrabursal injections of betamethasone were found effective in this series of bursitis and arthritis patients.

Betamethasone In Arthritis And Bursitis

Keith E. Haines, M.D./Camden

Once it was hoped that cortical steroids would become the definitive cure, or even repeat the miracle of insulin in diabetes as a "physiologic replacement" drug in arthritic syndromes. This hope has not been realized, but these drugs have, nonetheless, led to a revolutionary advance in the treatment of these diseases. Development of technics and preparations for direct administration of steroids into the inflamed joints or lesions has been particularly useful in minimizing some of the potentially severe systemic side effects. Even various types of localized side effects,[1] especially the so-called "rebound flare" and related phenomena presumably ascribable to irritative effect of relatively insoluble drug crystals,[2] have become less frequent since the development of more soluble steroid preparations. Indeed, for this specific route of administration, the vastly enhanced ratio of potency of the more recent hydrocortisone analogs is in itself a great advantage, since it permits an adequate therapeutic effect with a minute volume injected into the joint.

In our practice in this highly industrialized urban area of southern New Jersey, we habitually treat a large number of patients with traumatic, or occupational bursitis, especially subdeltoid bursitis; and degenerative arthritis, particularly of the knee and other joints. This has afforded us ample opportunity to try all these methods of therapy. Over the past few years, we have used great quantities of the newer, low-dose steroids such as triamcinolone and prednisolone (for intra-articular and periarticular administration).

Recently, we have had the opportunity of using a new preparation containing betamethasone.* This is prepared for intra-articular, intrabursal, and intralesional administration. Our results with it are reported below.

The preparation is an aqueous sterile solution of equal amounts of two soluble esters of the new corticosteroid drug betamethasone, the 16-beta-methyl analog of dexamethasone. It is stronger than dexamethasone, one of the most potent anti-inflammatory corticoids known. It is an aqueous solution. Absorption of the highly soluble betamethasone disodium phosphate ester into the tissues is reported to be virtually immediate following injection. The betamethasone acetate is resorbed somewhat more gradually. The combination thus provides immediate and sustained relief. Studies[3] reporting generally satisfactory results with this preparation have been published recently.[4]

TABLE 1
AGES AND SEX OF PATIENTS

Age Group	Male	Female	Total
20-29	5	2	7
30-39	4	7	11
40-49	7	8	15
50-59	17	12	29
60-69	6	10	16
70-75	3	1	4
Total	42	40	82

* We used the brand of betamethasone tradenamed by Schering as Celestone,® in the form of a "Soluspan-TM" in which disodium phosphate and acetate salts of betamethasone are supplied in suspension.

The patients here reported represent an unselected group seen in our office practice. Most were middle-aged or older. As evident from Table 1, all but 18 of the 82 had reached or passed the fifth decade of life. In nearly one-half, the condition was chronic in that it had been present for at least 6 months. Specific traumatic antecedents (mostly rather severe industrial or traffic accidents) were present in 22 out of the 82. It was "chronic" in 15 of these. Only in 35 of the 82 was the duration of complaints less than 6 months with no history of trauma. Previous treatment with various anti-inflammatory agents, including either systemic or intralesional steroids or both, had been carried out in about one-half of the cases. Bursitis, mostly subdeltoid, was diagnosed in 34; degenerative arthritis, mostly of the knee joint but also of other joints, was present in 28; and miscellaneous other inflammatory myoarthritic conditions were diagnosed in the remaining 20.

All patients were carefully questioned and examined to exclude absolute or relative contraindication to topical glucocorticoid treatment, paying special attention to the possibility of active infective process in the joints, advanced joint destruction or fracture involving the joints. The severity of the symptoms and objective signs were recorded at the start of the project. We did use routinely local anesthesia as reported by others.[4] Scrupulous antiseptic precautions, of course, are absolutely essential when injecting any glucocorticoid preparation into the joints or soft tissues, to avoid introduction of potential pathogens into the treated area. Depending on the size of the joint, we injected 0.5 to 2 cubic centimeters into the area with the usual precautions recommended for this type of treatment. At the next visit, usually a week or two later, the patient was queried as to the result and was re-examined. Side effects, if any, were scrupulously recorded. The administration was repeated if it was considered necessary. The same procedure was followed for the next few visits. No systemic treatment was given except for the administration of the oral anti-inflammatory drug phenylbutazone to eleven patients for short periods, and salicylates p.r.n. in an occasional instance. Physiotherapy, including local application of heat and whirlpool hydrotherapy, was also used as considered necessary.

Results

As is apparent from Table 2, one injection sufficed in 56 of our 82 patients. This group includes a few in whom more than one joint or lesion was injected on the same day. Two or three administrations were necessary in all but 3 of the remaining 26 patients. The results are classified in the 5 categories as shown in Table 2, which also illustrates the number of treatments in each diagnostic category. In general, patients who reported prompt and complete relief of symptoms, accompanied by objective signs including pronounced reduction or elimination of any previous restriction of motion range of the affected joints, were classified "very good." Relief which was partial only, or about the average expected or obtained with any corticosteroid medication, was classified as "good." Those showing only a minor but still definite degree of improvement were classified as "fair." In 12 of the patients we were unable to determine the effect of the treatment, because the patients failed to keep the next appointment and were not seen again during the subsequent several months. However, later reports (and circumstantial evidence in individual cases) indicated that most of these experienced very good results and failed to return simply because they felt well. Despite this, we have classified the results in these cases as "inconclusive."

Of the five patients who did not respond, one, a man aged 35, had a small tender fluctuant bursa of the left patellar tendon and tibial tuberosity. A 6 milligram injection of betamethasone* into the left knee produced no response. Hospital admission was arranged for surgical excision. The second case, our youngest patient in the group, was a man aged 20 with coccygodynia of unknown cause and marked tenderness of the sacrococcygeal joint and the coccyx. Six milligrams of betamethasone injected around the coccyx had

TABLE 2

RESULTS BY DIAGNOSES AND NUMBER OF TREATMENTS

Diagnosis	Number of Treatments	RESULTS OF THERAPY Very Good	Good	Fair	Nil	Inconclusive	Total
Bursitis (34 patients)	1	12	2	1	1	6	22
	2 or 3	3	6	0	2	0	11
	4, 5, 6	1	0	0	0	0	1
Degenerative Arthritis (28 patients)	1	12	3	0	0	3	18
	2, 3	1	5	2	0	0	8
	4, 5, 6	0	2	0	0	0	2
Miscellaneous (20 patients)	1	3	6	2	2	3	16
	2 or 3	1	1	2	0	0	4
TOTAL	1 to 6	33	25	7	5	12	82

no beneficial effect. Surgical removal of the coccyx was arranged with eventual satisfactory results. The third patient who did not benefit at all from the drug was a woman aged 46 with traumatic arthritis of the cervical spine and severe psychoneurotic symptoms and pain over the suboccipital and trapezius area. She had suffered injuries in a vehicular accident. Examinations (including cervical myelograms and neurosurgical consultations) did not reveal any objective abnormality. She had also received intensive physical therapy and was wearing a neck support that gave incomplete relief. The injection into the musculature of the trapezius muscle seemed to have no beneficial effect at all. The two remaining unsuccessfully treated patients had had right subacute subdeltoid bursitis with considerable restriction of movement. One patient had roentgenographically confirmed deposits of calcium in shoulder. The other revealed a very chronic condition previously unresponsive to corticosteroids with considerable fibrous adhesions in the shoulder. In the latter patient, benefit was later derived from manipulation of the shoulder under general anesthesia.

No local side effect was reported in any of our patients. In particular, it was gratifying to record the complete absence of a "secondary flare" phenomenon in injected joints. Careful observation, examination, and questioning also failed to reveal any of the usual signs of possible systemic side effects of steroids except for one questionable case. This was in a 44-year-old male diabetic who reported some difficulty in maintaining smooth insulin and dietary control of diabetes following injections of the betamethasone preparation at 8-day intervals. The injections were given into his subdeltoid bursa for an acute exacerbation of subdeltoid bursitis of 6 months' duration. The cause-and-effect relationship could not be determined. He had no other side effects and experienced effective relief of pain as well as a gratifying increase in the range of motion. The result was pleasing to this patient despite his minor difficulty with diabetes control. We have noted no sign of dimpling of the skin at the site of the injection, or of localized pain possibly indicative of crystal deposition. However (for unpublished studies by others), we understand that some such instances have been reported with betamethasone.* Although a considerable number of our patients have been previously treated with steroids (parenterally or orally), none of them was taking steroids systemically during the period of this study.

Discussion

In general, our gratifying results seem to be in agreement with other recent clinical reports[3] utilizing the same preparation.[4] Our

findings also seem to agree with a recently published Brazilian clinical study.[5]

As with any drug, there are some patients who will not respond. Successful treatment requires careful selection and determination of the relative importance of the inflammatory factor as acute or chronic component of the syndrome. While the acute condition usually subsides nicely with the compound, complete "cure" is rarely possible in the chronic cases. The patient must adjust his mode of life for optimal use of the affected joints. This may involve a delicate balance between excessive strain on the joint and subsequent exacerbation, and the equally deplorable excessive rest which may lead to eventual signs of functional atrophy.

Summary

1. A new injectable preparation combining the highly soluble disodium phosphate ester of betamethasone and the more slowly absorbed betamethasone acetate* was used in the treatment of 82 patients, including 34 with bursitis, 28 with degenerative arthritis, and 20 with various myo-arthritic inflammatory conditions.

2. Results were very good or good in 58, fair in 7, nil in 5, and inconclusive in 12. With treatments spaced at about weekly intervals, one treatment sufficed in 56 patients. Only three required more than 3 injections.

3. In general, the preparation was found to be highly satisfactory for direct intra-articular, intrabursal, or intralesional treatment. It was more effective for this purpose than the large quantities of prednisolone or triamcinolone preparations which we have used in the past. The local tolerance was excellent, and there were no side effects except for one doubtfully related case of temporarily increased insulin requirements in a middle-aged man with diabetes mellitus.

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You sometimes think you can palpate an area of cardiac dullness on the left, when it's only your imagination. This might be a case of dextrocardia.

Congenital Dextrocardia And Situs Inversus Totalis

A Case Report of Early Newborn

Annop Intharakoses, M.D./Trenton

Congenital dextrocardia, one kind of malposition of the heart in the right hemithorax, has interested physicians since 1643 when Severius first observed dextrocardia in complete *situs inversus*.[1]

Congenital dextrocardia may be an isolated anomaly; or it may occur in combination with a reversal of all the organs of the body. The latter anomaly is known as *situs inversus*. There is a misconception[2] that complete reversal of all the organs of the body is rarely associated with an additional abnormality of the heart, whereas the rotation of the heart alone usually results in some cardiac malformation. Merklin[3] found that approximately twenty-eight percent had cardiac defects. Two kinds of dextrocardia are known:[4]

1. The mirror image or classical dextrocardia. This is usually associated with complete *situs inversus*. The cardiac silhouette is a perfect mirror-image.

2. Dextrorotation or dextroversion is a completely different entity, both morphologically and embryologically. This is not associated with *situs inversus*, but is frequently seen with cardiac anomalies.

The possible mechanism of formation of *situs inversus* and dextrocardia can be considered in two aspects:

1. The genetic aspect. Cockayne[5] considered complete *situs inversus* to be an inherited recessive characteristic determined by a single autosomal gene. Campbell,[6] evaluating forty families, also found evidence of a recessive mode of inheritance. There is a higher incidence of consanguinity in families with dextrocardia.[7]

2. The embroyogenic aspect. Von Woell Worth[8] was able to produce a high incidence of *situs inversus* in the gastrular stage of the pig embryo by producing a defect in the primitive mesodermal region over-lying the left side of the primitive gut. He suggested that there is a symmetrical "organizer" in the mesoderm which influenced the subsequent rotation of the gut and which was operative during the gastrula stage.

Dextrocardia results from the initially reversed placement of the primitive atria. The primitive atrial orientation as to right and left serves as an anchor point around which all the other heart structures will develop.

Completed transposition of viscera is uncommon. Previous estimates[9] of incidence vary from 0.07 per cent to 0.002 per cent of births. Torgersen[10] found only one in ten thousand persons. Lowe and McKeown[10] found one in seven thousand persons. The incidence of dextrocardia in this study was 0.0015 per cent.

Dextrocardia plus *situs inversus totalis* is a complete inversion of the thoraco-abdominal organs without structural deformity. The stomach bubble is on the right, the liver is on the left, the ascending colon is to the left. The left lung has three lobes, and the right lung has two lobes. The spleen is always under the right side of the diaphragm.

A newborn male was admitted to the hospital after being born the day before at home spontaneously and without apparent difficulty. The baby was the sixth

child, the result of a full-term delivery without any complication during pregnancy. Birth weight was 8 pounds, 4 ounces. There was no *situs inversus* or consanguinity in the family history.

He was a well-developed baby, with no jaundice or anemia and no external malformation. Body measurements were within normal limits. There was no lymphadenopathy. The nervous system, lungs, eyes, ears, nose, and throat were all normal.

The apical beat could be palpated just below the right nipple. No cardiac thrill was palpated. On percussion there was a normal area of cardiac dullness, but it was in the right hemithorax. No murmur was audible. Apex sounds were clearly heard below the right nipple. The abdomen had a normal contour and no hepatosplenomegaly or abnormal masses were palpated. Liver dullness was percussed in the *left* hyperchondrium. The extremities appeared normal in size and configuration. Laboratory studies of the blood and urine were normal except for a hemoglobin of 9 grams percent. The electrocardiogram was compatible with the diagnosis of dextrocardia. All the complexes are inverted in lead 1 and in AVL, while they are upright in AVR. The precordial leads are taken from left to right and are compatible with dextrocardia.

X-ray examination of the chest confirmed the clinical diagnosis of dextrocardia. The lungs and pleura were within normal limits, and there was no tracheal shift. The heart was rotated 180 degrees facing to the right due to the congenital dextrocardia. The bulk of the liver shadow was in the left upper quadrant, and there appeared to be a normal gas-filled splenic shadow in the right upper quadrant. Radiographic cardiac series, in multiple projections after ingestion of barium, showed again the presence of total situs inversus with dextrocardia. Upper gastrointestinal x-ray study demonstrated complete *situs inversus* with the liver on the left and the spleen on the right. Barium x-ray study showed the colon, liver, and spleen to be inverted.

Congenital dextrocardia is not so rare. In a way, it is a test of the physician's acuity in physical diagnosis. The functional capacity of the heart is unaltered. There are no murmurs and no thrills. Clubbing and cyanosis are absent. Indeed, there may be nothing to attract attention to dextrocardia. If the physician thinks about dextrocardia, he usually experiences no difficulty in the percussion of the heart in the right hemithorax. When unaware of the lesion, many persons have thought that they could describe the area of cardiac dullness on the left. Congenital dextrocardia and *situs inversus totalis* may be accompanied by severe intracardiac and extracardiac anomalies. Arcilla[12] and others reported 11 cases of congenital dextrocardia (mirror image dextrocardia and *situs inversus totalis*). Six of these cases (55 per cent) were associated with other intracardiac anomalies. Campbell and Reynold[13] reported 9 of 11 of their patients to have complicating congenital heart disease.

Accompanying intracardiac anomalies are common. *Situs inversus totalis* is of minor importance in terms of incidence. Its clinical significance, however, assumes major proportions when it is realized that many of these individuals have defects incompatible with normal existence.[14]

Some of these associated intracardiac anomalies exhibit symptoms and signs such as dyspnea, cyanosis, clubbing of fingers in the early, even neonatal, life.

In later life, if a person with this syndrome gets manifestations in the left iliac fossa, the diagnosis of appendicitis may be missed if the physician had not known about, or detected, the *situs inversus.*

Some of the latent intracardiac malformations can be corrected surgically.

As with much else in clinical medicine, there is no substitute for alertness in the doctor, and for the philosophy of taking nothing for granted.

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St. Francis Hospital

A possible, but rarely reported, association between griseofulvin and lupus erythematosus is here demonstrated. Positive L. E. cell tests in one of these cases make this a unique report.

Griseofulvin and Lupus Erythematosus*

William A. Anderson, M.D.
Douglas Torre, M.D.
/ **Orange**

Griseofulvin for systemic treatment of certain fungus infections has proved to be remarkably safe in spite of occasional side effects such as nausea, diarrhea, headache, and temporary granulocytopenia.[1] Skin eruptions, including one case of exfoliative dermatitis[2] and angioneurotic edema,[3] have been reported.[4] Here presented are two cases, including one in which lupus erythematosus tests were positive. This is the first instance of this finding ever reported.

Case One

An eleven year old boy had a history of an erythematous, slightly pruritic eruption of the butterfly area of the cheeks and nose of one day's duration. Three months ago, he had taken griseofulvin by mouth for treatment of tinea capitis for two weeks, and again for four days prior to the onset of the skin eruption. Several years ago he had had a generalized urticarial eruption associated with penicillin administration for a urinary tract infection.

On examination, we found a dusky, confluent erythema with indistinct borders over the nose and malar eminences. The patient was afebrile; the sedimentation rate was 17 millimeters per hour; a blood count and urinalysis showed no abnormal findings. A lupus erythematosus cell test was negative. The skin eruption disappeared within one week of onset. The patient has been well since, except for a 48-hour episode of facial edema, fever, and malaise which developed a year later following several hours of intense sun exposure at the beach. The lupus erythematosus cell test and other routine laboratory test results were again normal.

Case Two

A 33 year old woman was admitted to the New York Hospital complaining of a skin rash and joint pains. These symptoms had begun a few weeks prior to admission after six months of continous oral therapy with griseofulvin for a severe Trichophyton rubrum infection of the fingernails, toe nails, and skin of the hands and feet. She had a reddish brown macular eruption on the arms and thighs. The centigrade body temperature was 38.2. The left knee, both wrists, and the proximal interphalangeal joint areas were edematous and tender. Positive laboratory findings included an elevated sedimentation rate, repeated positive lupus erythematosus cell tests, a positive L.E. n-pelide test, a 2 plus latex fixation test, and complement fixing with DNA at 1 to 2 dilution.

Under treatment with adrenal corticosteroids, the skin rash disappeared and the acute symptoms subsided. However, she has had repeated attacks of arthritis requiring treatment with corticosteroids and chloroquin to the present time. Laboratory signs of lupus erythematosus have persisted over this five-year period. A lupus erythematosus cell test was positive five years after the initial admission.

Two cases of lupus erythematosus like eruption have previously been reported by Alexander.[4] One was a 64-year-old male who had onset of an eruption "resembling early discoid lupus erythematosus" of the cheeks and forehead six days after griseofulvin had been started. His reaction subsided within a week of discontinuing the griseofulvin but for two years there were flareups of facial lesions on exposure to sunlight. The other case was in a 22-year-old female with a widespread rash, beginning on the hands and feet and spreading centripetally, with onset ten days after starting griseofulvin. The rash faded in four days on antihistamine medication. This patient had associated gastrointestinal complaints, headache, fever, hyperglobulinemia, leukopenia, and an elevated sedimentation rate. Both of these patients had *negative lupus erythematosus cell tests* and negative Kahn reactions. A positive Prausnitz-Kuestner test to griseofulvin was demonstrated in the sec-

* From the Division of Dermatology, New York Hospital – Cornell Medical Center, New York.

ond patient. Complement-fixing antibody to griseofulvin was present in both cases. Control complement-fixation studies to griseofulvin in three patients with lupus erythematosus and twelve other patients taking griseofulvin were negative.

Alexander based the diagnosis of lupus erythematosus on findings of leukopenia, elevated gamma globulin in the second patient, positive complement fixation with DNA and white blood cell extract in both cases, and similar behavior of the second patient's serum to that of a patient known to have lupus erythematosus in Coombs consumption test using chicken red blood cells.

Comment

Lupus-like eruptions following griseofulvin administration are probably in the nature of a phototoxic or photoallergic drug eruption. They are transient, and no laboratory evidence of lupus erythematosus is present. The role of porphyrins in these cases is not well understood. Hurst and Paget[5] produced protoporphyrin in animals by administering griseofulvin, and Rimington and his co-workers[6] present evidence that griseofulvin in therapeutic dosage has a disturbing effect on human porphyrin metabolism and that such a disturbance tends to persist for some time after the drug is withdrawn. However, as all of their patients had a concomitant fungus infection, they could not rule out the possible effect of the tinea infection *per se* on porphyrin metabolism, although such effects have not been otherwise reported.

Whether the lupus erythematosus is caused by, aggravated by, or coincidental to the administration of griseofulvin is not clear. However, Alexander's report of two cases of lupus erythematosus like eruption beginning with griseofulvin[4] and the reported exacerbations of lupus erythematosus[7,8] indicates more than a chance association.

The most likely mechanism is that griseofulvin triggers a preexisting, but latent, lupus erythematosus state. This hypothesis is supported by the rarity of this condition following griseofulvin and by the reported exacerbations[7] in patients with pre-existing lupus erythematosus.[8] Lupus erythematosus eruptions (or true lupus erythematosus) have followed treatment with many drugs including hydralazine,[9-11] mesantoin,[12] procainamide hydrochloride,[13-15] and antituberculous drugs.[16] Alarcon-Segovia and his co-workers[9] present good evidence that, when hydralazine therapy produces clinical lupus erythematosus, a "lupus diathesis" is present in the majority of patients. Reporting on 50 patients, they found that 74 percent had antedating manifestations possibly suggesting a lupus diathesis, but only 13 percent of a control group of 100 hypertensive patients had these manifestations. In their series, 33 of 37 patients tested had positive lupus erythematosus cell preparations. Clinical and laboratory manifestations of lupus erythematosus persisted for years in more than two-thirds of the patients.

Summary

Two cases are presented. The first developed a lupus erythematosus-like facial eruption following griseofulvin administration. This is most likely a photo-allergic drug eruption. The second patient developed true lupus erythematosus following treatment with griseofulvin. It is the first such case reported with positive lupus erythematosus cell tests. Whether the lupus erythematosus was caused by, aggravated by, or coincidental to the administration of the griseofulvin cannot be decided on a single case, but reports in the medical literature indicate more than a chance association.

A bibliographic listing of references will be found in Dr. Anderson's reprints.

68 Central Avenue

Biliary atresia may be due to a choledochal cyst, as Dr. Spiro here reminds us.

Congenital Choledochal Cyst Simulating Biliary Atresia*

Alfred J. Spiro, M.D./Philadelphia, Pa.

In spite of thorough clinical and laboratory evaluation of an infant with jaundice, an exact etiologic diagnosis prior to surgery is often impossible. This difficulty was manifested in the following case in which a choledochal cyst closely simulated biliary atresia in an infant. Very few reports[1] of similar circumstances[2] appear in the literature.[3] Cognizance of this possibility is necessary to afford the patient proper surgical correction.

A 4-month-old baby was admitted to the hospital for the evaluation of jaundice. The child was the product of a full term pregnancy which was normal except for an illness in the first trimester. The mother for about a week had had chills, fever, anorexia, and sore throat. There was no blood incompatibility and no known contact with hepatitis. This was the mother's first pregnancy and delivery was uncomplicated. She had not received any medication. The child received a small intramuscular injection of vitamin K immediately after delivery. The mother, seeing her baby for the first time, thought she had an "oriental" hue to the skin. The sclerae were thought to be yellow tinged for several weeks prior to admission to the hospital. During these weeks, progressively darkening urine and intermittently depigmented stools were noted. The baby's general condition was excellent; feeding and weight gain were normal. There was nothing in the history suggestive of abdominal pain.

On physical examination, the child appeared well. She fit into the fiftieth percentile for length, weight, and head circumference. Developmental landmarks were consistent with her age. The skin, sclerae, and mucous membrane of the mouth appeared slightly jaundiced. The liver edge was palpable 3 centimeters below the right costal margin, and the spleen edge was palpable 10 millimeters below the left costal margin; both these organs had a fairly firm consistency. No abdominal masses or lymph nodes were palpated. The remainder of the physical, neurologic, and ophthalmologic examinations were within normal limits.

On admission the complete blood count and reticulocyte count were normal, as was the routine and microscopic urine analysis. Repeated examinations of the urine showed consistently positive tests for bile and negative tests for urobilinogen. Coombs' tests were negative. The infant's blood type was O positive. The alkaline phosphatase was 15.5 Bodansky units and the total serum protein was 6.9 Grams with 5.0 Grams of albumin and 1.9 Grams of globulin per 100 milliliters. Serum glutamic oxaloacetic transaminase was 109 units. The total bilirubin was 3.6 milligrams per 100 milliliters with 3.5 milligrams of the direct reading type. During hospitalization, the direct reading bilirubin rose steadily to a peak of 9.4 milligrams per 100 milliliters. The prothrombin activity was 75 per cent of a normal control. The cephalin flocculation was 0 units and the thymol turbidity varied between 3 and 9.3 units. Blood urea nitrogen and glucose determinations were normal.

Urine examinations showed negative tests for cytomegalic inclusion bodies and galactose. Serologic tests for syphilis were non-reactive. Urine and blood were cultured and showed no growth. Fluid removed via duodenal lavage proved negative for bile. An intradermal PPD was negative. X-rays of the chest, skull, and abdomen were negative.

The mother's blood was type O-positive. Bilirubin, cephalin flocculation, thymol turbidity, and serum glutamic oxaloacetic transaminase reactions were all within normal limits.

An intravenous cholangiogram was not done because of jaundice. The tentative diagnosis was biliary tract atresia, with neonatal hepatitis to be excluded. The infant was scheduled for exploratory laparotomy with liver biopsy and operative cholangiography. Due to two minor upper respiratory infections, surgery was delayed. At the time of surgery, the infant was 5 months old.

Laparotomy (Dr. Norman Tarr) was under nitrous oxide and cyclopropane anesthesia given *via* endotracheal tube. Through a right rectus incision all tissues appeared icteric. The cecum and appendix were

* From the Department of Medicine (Pediatrics), United States Public Health Service Hospital, Staten Island, New York. Dr. Spiro, a member of The Medical Society of New Jersey, is now with the Children's Hospital of Philadelphia.

TABLE

REPORTED CASES OF CHOLEDOCHAL CYSTS SIMULATING BILIARY ATRESIA*

Author	*Signs or Symptoms*	*Pre-operative Diagnosis*	*Surgery*	*Follow-up*
Carter[1]	Clay stools, jaundice; no abd. pain or mass	Biliary atresia	Cholecystogastrostomy	Recovery
Dickinson[2]	Clay stools, dark urine, jaundice; no abd. pain or mass	Biliary atresia (low bilirubin level unusual)	Anastomosis of cyst and GI tract	Well 6 mo. post-op.
Sulamaa[3]	Clay stools, dark urine, jaundice; no abd. pain or mass	Biliary atresia	Choledochocystoduodenostomy	Well 1 mo. post-op.

* All were female.

in the right upper quadrant. A small Meckel's diverticulum was also present. A small gall bladder (only 1 by 4 centimeters) was present but there was no bile in it. A cystic mass 5 by 3½ by 5 centimeters comprised the choledochal duct. Needle puncture revealed this structure to contain 25 cubic centimeters of normal colored bile. The liver had a fine granular appearance.

The choledochal cyst was anastomosed to the second portion of the duodenum by a two-layered interrupted silk closure forming an anastomosis with a 1 centimeter diameter. The operating time was two hours and, because of the somewhat precarious condition of the patient, the surgeon elected not to do a liver biopsy.

Except for a mild febrile episode, the immediate post-operative course was uneventful. On the first post-operative day examination of the contents aspirated through a Levin tube showed the presence of bile. On the second post-operative day the stools became pigmented. Subsequent direct bilirubin determinations were as follows: 3.2, 1.9, and less than 1 milligram per 100 milliliters, 1 month, 2 months, and 4 months, respectively, post-operatively. Follow-up at 16 months of age (11 months after surgery) showed normal growth and development with no jaundice or anemia. The edges of the liver and spleen were barely palpable. Serum glutamic oxaloacetic transaminase, however, was 147 units. Due to transfer, the patient was lost to subsequent follow-up.

When the first two components of the triad — mass, abdominal pain, and jaundice — characteristic of choledochal cysts[4] are absent, the pre-operative diagnosis of this condition is virtually impossible. The surgeon, however, must be prepared to cope with this, if he finds it at the operating table. This case fits into the above category and simulated other forms of obstructive jaundice in a young infant. A sparse number of cases appears in the literature[1,2,3] in which choledochal cysts were found at surgery in infants below 6 months of age in whom no abdominal mass was palpated pre-operatively and in whom atresia of the bile ducts had been considered. (See the table). A relatively low level of bilirubin (2.5 milligrams per 100 milliliters direct and 5.1 milligrams indirect) in the case of Dickinson and Spencer[2] was considered unusual for biliary atresia. Anastomosis between the cyst and the gastrointestinal tract was done in all of the cases with apparent recovery. This high success rate does not reflect the substantial mortality and morbidity generally reported with unselected cases of choledochal cysts. Although the sole presence of females in the small, arbitrarily selected group has no statistical significance, *per se*, there is a marked preponderance of female patients with this disorder.

For a comprehensive review of choledochal cysts in all age groups the reader is referred to the article by Alonso-Lej and his associates.[4]

Summary

A 4-month-old infant with a clinical picture of biliary atresia was found to have a choledochal cyst at surgery. Following choledochocystoduodenostomy the infant recovered but a degree of hepatic defect remained. Similar cases from the meager literature are tabulated.

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Children's Hospital

The giant condylomata of Buschke and Lowenstein have frequently been reported. But here is a variant with malignant change which seems not to have been emphasized before.

Giant Condylomata Accuminata Associated with Carcinoma*

Austin S. Litvak, M.D., Irving Melnick, M.D. and Paul R. Lieberman, M.D. / **Long Branch**

Condylomata accuminata are common, but usually benign, lesions of the penis, successfully treated by conservative means. However, the "giant condylomata accuminata" of Buschke and Lowenstein[1] appears to be a different disease. The difference is further compounded by possibility of changes indicative of malignancy.[2,3] These changes have not been much emphasized, and we here report a case illustrating the malignant potentiality, the failure of conservative therapy, and the need for radical extirpative treatment.



Figure 1. Giant condylomata accuminata with carcinoma involving external genitalia.

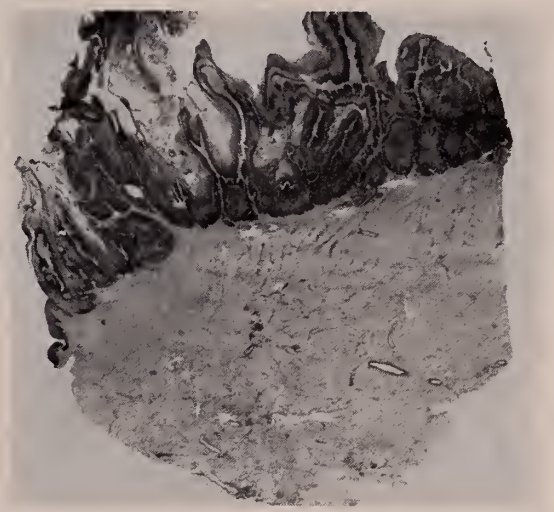


Figure 2. Low power microphotograph showing deep growth and displacement of underlying tissue.

A 39 year old man had noticed several small "warts" on his foreskin and penis in 1948 while on military duty in the South Pacific. These lesions had not progressed in size until 1964, when they suddenly began to increase in size, to spread, and to bleed freely. There had been no urinary symptoms. Gonorrhea, syphilis, and sexual contact were denied during the period when the lesions were first noted.

Past medical history, family history, and review of systems were negative.

Initial physical examination revealed multiple, exudative, warty, freely bleeding lesions extending over the penis, scrotum, and suprapubic areas (Figure 1).

* From the Department of Urology, Philadelphia General Hospital, Philadelphia, Penna.

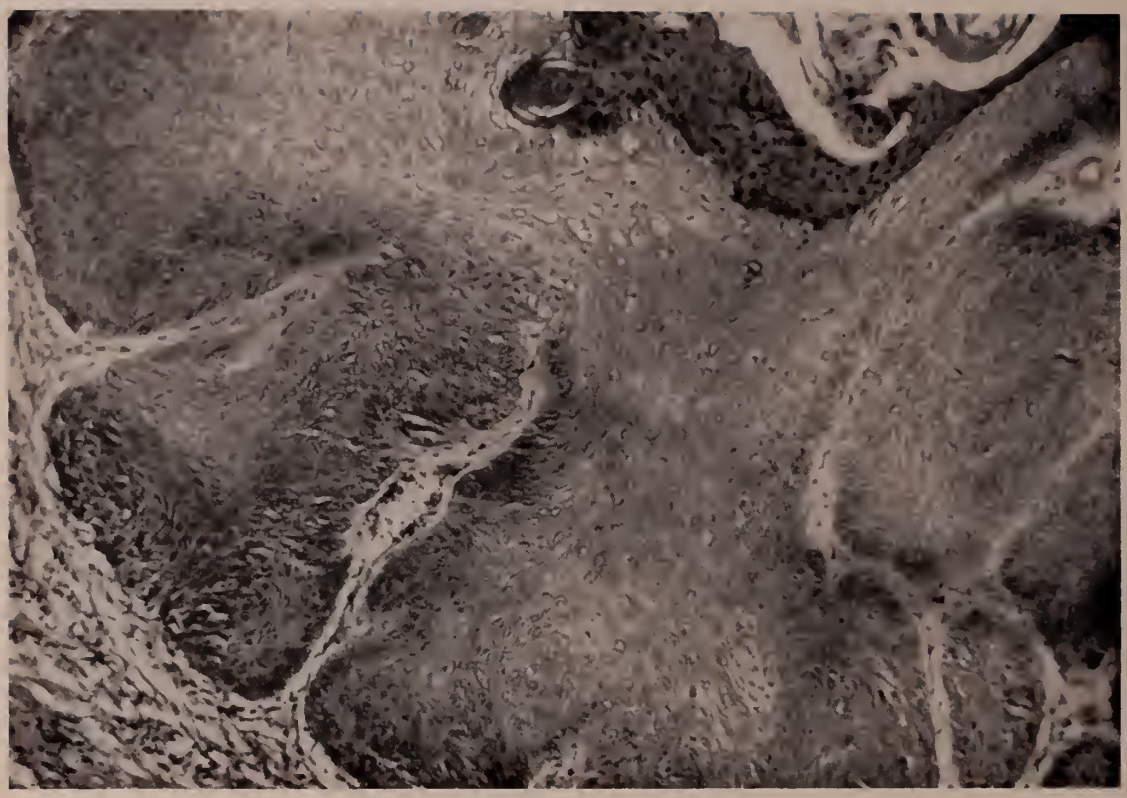


Figure 3. High-power microphotograph showing atypism and frequent mitoses.

The conjunctivae and mucous membranes appeared pale. The inguinal nodes were enlarged bilaterally. There were no other significant physical findings. The Frei test was negative and the V.D.R.L. was non-reactive. Urinalysis was normal and stools were negative for blood. Chest x-ray revealed old scarring in the left costovertebral angle and above the left diaphragm. He had a hemoglobin of only 5.5. This anemia was felt to be on the basis of chronic blood loss from his genital lesions. The anemia was corrected with whole blood and multiple biopsies were taken. The biopsies presented a differential diagnostic problem: pseudoepitheliomatous hyperplasia or squamous cell carcinoma. The patient was seen by the Department of Dermatology, and a 30-day course of aminopterin (2 milligrams a day) was given. There was only slight regression of the lesion. Tuberculosis and fungus cultures of the lesion were negative.

A second biopsy was carried out after the course of aminopterin. This was reported as an epithelioma due to the many mitotic figures seen. Review of the slides by the Pathology Department of the Skin and Cancer Hospital of Philadelphia showed carcinoma *in situ* with atypical epithelial changes suggestive of erythroplasia of Queyrat (Figures 2 and 3).

Bacterial culture of the lesion revealed pseudomonas resistant to all antibiotics. Progressive growth of the lesion continued. Then abscess formation began. The abscesses were opened and pseudomonas was again cultured out. One month later the entire superpubic area was excised. Review of the slides by the Skin and Cancer Hospital resulted again in the diagnosis of carcinoma *in situ*. The denuded area rapidly became reseeded with the lesion. Retrograde femoral angiography and lymphangiography showed at this time no evidence of metastatic nodal involvement.

The patient refused radical extirpative surgery at this time and was started on podophyllin applications without benefit. He began to develop sinus tracts and more and more local infection with abscess formation and spread of the growth.

He was started on soaks of Chloropactin® XCB, three times a day for 15 minutes at a time. Rapid clearing of the superficial infection was then noted as well as some recession of the exuberant growth and the appearance of healthy granulation tissue in the denuded areas.

Split thickness, postage stamp grafting of the suprapubic area was carried out with 90 per cent take. Then, he developed a penile urethrocutaneous fistula.

The patient now agreed to an aggressive approach to his problem, and total surgical extirpation was undertaken. Total penectomy, scrotumectomy, bilateral orchiectomy, and deep excision of the inguinal and suprapubic areas were carried out. The denuded areas were covered with split thickness skin graft and a take of 90 per cent was obtained. The wound healed well and the patient was discharged in good condition.

The patient was seen with a small recurrence of the perineum eight months later which was excised and closed with good results. When last seen two years following the radical surgery, there had been no further recurrences (Picture 4).

The entity known as giant condylomata acuminata of Buschke and Lowenstein[1] presents



Figure 4. Postoperative view. Note the perineal urethrostomy.

a pathologic picture differing somewhat from the lesion described above. In giant condylomata there is a very thick stratum corneum with a marked tendency to grow deeply and displace underlying tissues. Mitotic figures and pearl formation are rare and there is an absence of actual invasion or infiltration.

Pathologic findings in this lesion revealed considerable pleomorphism and dyskeratosis. Mitotic figures and pearl formation are present but there is an absence of actual invasion.

Thus, we seem to have three different disease entities: the common condylomata accuminata, the giant condylomata of Buschke and Lowenstein, and a third variant with carcinomatous changes present. To our knowledge, the existence of this third type has not been emphasized before and its existence as well as the failure of conservative therapy should make extirpative surgery the preferred treatment when confronted by a patient with giant condylomata of Buschke and Lowenstein.

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255 Third Ave. (Dr. Litvak)

EXHIBITS: YOUR THREE-WAY TREAT!

One of the colorful aspects of any medical convention is the array of exhibits. This year, your Society provides three classes of exhibits: Informational, Historic, and Technical. Take the time to inspect all of them — not just a looksee and not a once-over-lightly scanning, either. But a real, indepth study. You'll be surprised how much you can learn.

The availability of solid carbon dioxide therapy is opening new doors to the dermatologist, especially for keloid-prone patients.

Action and Indications for Solid Carbon Dioxide Therapy In Dermatology*

Sam C. Atkinson, M.D./Summit

Intense cold is useful in the destruction or inhibition of many superficial lesions. Solid carbon dioxide has been used for many years in block form or pulverized to form "slush." The routine indications are well known to specialists dealing with superficial lesions. Recently the mechanical cooling apparatus (Linde Company) has been successfully used by Cooper[1] in brain tumors, and there is a possibility of wider use of cryosurgery in other fields of medicine. Meryman[2] suggests that the mechanisms through which cold produces destructive changes include: (1) dehydration and toxic concentration of electrolytes due to removal of water, (2) intracellular crystallization with rupture of cellular membrane, (3) denaturation of liquid protein molecules within the cell, and (4) thermal shock.

During the past fifteen years, I have used solid carbon dioxide extensively in severe cystic acne as suggested by Wright[3] and Carpenter.[4] I much prefer the solid form over the "slush," because it is more convenient and efficient. It produces more controllable reaction by virtue of pressure. Therapeutic advantages of cryotherapy over other modalities include avoidance of keloids, reduction of hemorrhage, and fast healing. Disadvantages noted are blistering, painful discomfort, and depigmentation.

* Read before the Section on Dermatology at the Annual Meeting of The Medical Society of New Jersey on May 19, 1965.

Method

Solid carbon dioxide blocks are available where ice-cream is sold. The blocks are typically kept in insulated, large-mouthed containers. A ten pound block, properly refrigerated, can last as long as three days.

The appropriate-sized piece is cut or chipped off with a hammer and a sharp knife. Further shaping is needed to eliminate sharp edges. If a small applicator is preferred, the Kidde apparatus is a more convenient source of carbon dioxide.

The lesion to be treated is first cleansed with alcohol. Excess keratin and debris are curetted away, preferably after procaine anesthesia. The properly shaped CO_2 applicator is pressed firmly onto the lesion until the lesion is solidly frozen. If there is doubt about the depth of freezing, additional curettage of overlying epidermis is sometimes necessary. An interval of ten to thirty seconds is usually sufficient, but this varies with the type and depth of the lesion. Acne is treated with less pressure, and the CO_2 is kept moving in a sliding fashion. Angiomas, especially in babies of less than six months of age, are treated for about two to five seconds. Experience is needed to avoid overtreatment.

Follow-up examination in benign conditions is done on the basis of observation. With regard to basal cell carcinomas, re-treatment and repeat biopsies after one and two weeks are desirable or until a negative biopsy is obtained.

Results

Solid carbon dioxide was found superior to other modalities in:

1. **Leishmaniasis tropica:** In one patient with multiple lesions, solid CO_2 was curative following two strong applications at weekly intervals. Medical (antimony) therapy was too time-consuming for this patient. It is generally undependable.

2. **Swimming pool granuloma** (caused by Balnei bacillus). (Two patients) Solitary lesions were treated very successfully with strong applications of CO_2. These areas had been unresponsive to steroid-antibiotic salves and intralesional steroids.

3. **Acne:*** Numerous patients resistant to other forms of therapy including x-radiation, ultraviolet light, and antibiotics have responded satisfactorily to solid CO_2. The scars, cysts, and foreign body granulomatous lesions were greatly reduced by multiple treatments with or without surgical aids. Deep liquified cysts are best treated with intralesional triamcinolone.

4. **Verrucae:*** Solid CO_2 is particularly useful in treating flat warts and large plantar warts. Preliminary curettage is necessary for very deep warts. Scarring is reduced by this method as compared to electro-coagulation.

5. **Keratoses:*** Senile and seborrheic keratoses are best treated with solid CO_2 in the keloid prone individual and for maximum cosmetic results in all cases. Solid freezing facilitates curettage of the elevated hypertrophic elements and eliminates the need for novocaine.

6. **Angiomas*** (superficial-strawberry colored): These lesions are treated very successfully with minimal pressure for one to two seconds at two to three week intervals. Care must be taken to avoid overtreatment reaction and ulceration in a situation where spontaneous involution may take place. Furthermore, patients should be treated prior to six months of age; response is usually poor after that time.

7. **Small keloids and hypertrophic scars:** (25 patients) Both conditions are responsive to blistering doses of solid CO_2. Large keloids may need surgical excision and/or x-ray therapy to achieve satisfactory results.

8. **Synovial (myxoid) cysts of phalanges:** (6 patients) CO_2 therapy, although painful, is much superior to x-ray therapy, cortisone injections, and surgery. Strong heavy pressure resulting in a blistering reaction is needed, but the cysts flatten down with one or two treatments.

9. **Basal cell carcinomas:** (4 patients) Superficial, multiple lesions of less than one centimeter in depth are ideally treated with solid CO_2 after curettage of excess crust and granulation tissue. Follow-up biopsies are important, and occasionally a second treatment is needed. Keloid and hypertrophic scarring is eliminated by this procedure, and cosmetic results are superior to all other forms of therapy.

Solid carbon dioxide therapy was found useful as *adjunct treatment* in discoid lupus erythematosus and in folliculitis or acne keloid. I had three patients with the latter condition, and it was greatly improved by combination CO_2 therapy and surgical planing. Internal antibiotic and local antiseptic therapy are usually ineffective in this chronic condition.

10. **Discoid lupus erythematosus:** (7 patients) For the elevated verrucous elements, solid CO_2 is occasionally useful after intralesional steroid injections have failed.

In general many elevated, granulomatous, verrucous, or papillomatous lesions can be improved with cryotherapy. The diagnosis must be properly established by biopsy.

Conclusion

Solid carbon dioxide therapy has definite usefulness in dermatology. Often, it is the treatment of choice, especially in the keloid prone individual. In my experience, the scarring is reduced and healing is accelerated after CO_2 therapy as compared to electrocautery tech-

* 50 or more patients.

nics. This is particularly true with basal cell carcinomas.

Solid CO_2 represents an alternate form of therapy for those patients who have had excess radiation therapy in the past; or where procaine is not wanted; or where an allergy to procaine exists. Carbon dioxide is particularly useful in acne as adjunct therapy in elevated, cystic, papular lesions, and keloidal sequelae. There is no contraindication to combining this procedure with ultraviolet light or x-radiation.

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126 Summit Avenue

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P. O. Box 904, Trenton, New Jersey 08605

STATE ACTIVITIES

Trustees' Minutes

March 20, 1966

A regular meeting of the Board of Trustees was held on Sunday, March 20, 1966 at the Executive Offices. For the fuller information of the members, detailed minutes are on file with the secretary of your county society. A summary of the significant actions follows.

Blood Bank Commission . . . Re-designated the following as MSNJ's official liaison with the New Jersey Blood Bank Commission:

Jerome G. Kaufman, M.D., Maplewood
John J. Torppey, M.D., Newark

Medicare Program . . . Received the announcement by HEW that, on March 18, New Jersey was one of three states (Colorado and Iowa) which were the first to sign up out of 19 states that have indicated their intentions to cover persons who receive public assistance payments in the medical insurance part of the Medicare Program by a direct agreement with the Federal Government.

AMA Board Committees . . . Noted with satisfaction — and accepted as a measurable result of MSNJ's appearance before the AMA Board in Philadelphia last June — the following actions of the AMA Board:

(1) Request that its special committees, composed of AMA Board members, review current programs of committees and councils, with the objective of suggesting changes that would result in improved functioning, with minimal overlapping and duplication of program.

(2) Establishment of a committee of the Board to study organization procedures and methods of operation of the Board and its related councils and committees, and to make recommendations for improvement.

. . . Commended the AMA for this action, and offered the assistance of MSNJ to the AMA Board for any discussion in this area.

Crippled Children's Commission . . . Re-nominated, to the Governor, Dr. Frederick G. Dilger of Hackensack, for re-appointment as a member of the New Jersey State Crippled Children's Commission — on which Dr. Dilger has served successively since 1940.

Cancer Skin Tests . . . Approved the recommendation of the Cancer Control Committee that the New Jersey State Department of Health be requested to evaluate those laboratories which utilize skin tests for the detection of cancer.

Pap Test . . . Approved the recommendation of the Cancer Control Committee that MSNJ support — in cooperation with the New Jersey Division of the American Cancer Society — an intensive educational campaign among all physicians to utilize the "Pap" test.

Safety Bulletins . . . Agreed with the Committee on Child Health that a series of safety bulletins recently distributed by the American Academy of Pediatrics were worthy of much wider dissemination and utilization; and approved the following recommendations of the committee in this connection:

(1) That the Executive Director of MSNJ receive permission to reproduce these safety bulletins from the Accident Prevention Committee of the American Academy of Pediatrics, Inc. (of Evanston, Illinois).

(2) That sample copies be forwarded to the New Jersey Departments of Education and of Health, with the suggestion that they be utilized in connection with their respective departments, particularly as teaching aids.

(3) That the Executive Director of MSNJ reproduce these bulletins at suitable times of the year, in conjunction with Society programs on safety.

Safety Film . . . Agreed with the Committee on Child Health that the booklet "Panic/or Plan?" and its film companion, "Emergency 77" — developed with the cooperation of the AMA, the American Academy of Pediatrics, the American College of Surgeons, the National Safety Council, and the U.S. Department of HEW — are worthy of maximum usage before PTA groups in conjunction with local county speakers' bureaus; and adopted the following recommendations of the committee in this connection:

(1) That MSNJ encourage the use of this film before PTA groups, and that it be presented by a local physician, *when feasible.*

(2) That the New Jersey Congress of Parents and Teachers be informed of the availability of this film and the encouragement of its use in connection with local physicians.

Measles Vaccine . . . Approved the recommendation of the Committee on Child Health that MSNJ support measles vaccine as a requirement for school registration.

Newark Evening News . . . Authorized a letter of commendation to the publisher of the *Newark Evening News* and the cartoonist, Bill Canfield, for their outstanding efforts for the "Play It Safe" series.

Eye Health Screening Program . . . Approved the recommendation of the Committee on the Conservation of Vision that the 10th annual eye health screening program be held during the third week of September (18-24) 1966, in cooperation with the New Jersey Academy of Ophthalmology and Otolaryngology, the New Jersey State Department of Health, the New Jersey State Commission for the Blind, and the New Jersey Hospital Association.

Eye Pamphlet . . . Authorized the re-ordering of the pamphlet, "An Eye Health and Eye Screening Program for School."

Mental Health Committee . . . Approved the report and recommendation of the Committee on Mental Health, as follows:

The committee discussed the fact that, at the present time, MSNJ must deal with matters which require formation of subcommittees to the council or special committees from other groups within MSNJ. It was the conviction of the Committee on Mental Health that it could best serve the Society by elevation to the status and responsibility of an administrative council, with special committees under it on such current problems as alcoholism, drug addiction, mental retardation, mental illness of children and adolescents, epilepsy, neurological disorders, and psychiatric disorders of the aged.

To this end, the committee unanimously agreed that the following *recommendation* to the House of Delegates be made as an item of its annual report: That the Special Committee on Mental Health be elevated to the status of an administrative council, with special committees created by it to deal with alcoholism, drug addition, mental retardation, mental illness of children and adolescents, epilepsy, neurological disorders and psychiatric disorders of the aged.

Carrier Clinic . . . Agreed to co-sponsor with the Carrier Clinic an all-day seminar on "Psychiatry for the Physician," to be held at the Robert Treat Hotel in Newark on November 16.

Conference with County Presidents . . . Held its fourth conference with county presidents under the chairmanship of Dr. Dorothy Klughaupt of Passaic, and discussed the following items with them:

(1) *Anti-Poverty Program*

Concern was expressed about a Federal program of medical care for disadvantaged youth under the Anti-Poverty Program being conducted in various hospitals at local level. The group asked for detailed information concerning this matter and requested clearance of it at state level.

The Board reported that this matter had been dealt with at preceding meetings and reported in detail as follows:

Minutes of the meeting of the Board of Trustees
December 19, 1965, pages 191-192
January 16, 1966, pages 220-221

MSNJ JOURNAL
March 1966 issue, page 101

The Board reviewed the relevant materials referred to above, and the group agreed that they covered the matter satisfactorily.

(2) *County Utilization Review Committees*

Concern was expressed that so little information had been disseminated to local level concerning the function of these committees. It was reported that a committee has been established in almost every county, but no one is quite sure of its duties or scope of activity.

As Chairman of the Society's Council on Medical Services — which is the agency within MSNJ responsible for the Medicare Program — Dr. Marchione pointed out that everyone connected with the Medicare Program, including the Carrier and the fiscal agent, has confessed lack of specific information concerning it. What little information is available has been shared with component societies. As soon as more detailed information is forthcoming, it will be transmitted to local level.

(3) *Medicare Carrier*

It was reported that Prudential Insurance Company, as the Medicare carrier, plans to have two dinners in April, to which officers of component societies will be invited. Since, at its last meeting, the Board of Trustees had urged component societies to clear with the state Society rather than communicate directly with Prudential, advice was requested concerning acceptance of the dinner invitations.

The Executive Director reported that Prudential informed the Board that these two dinner meetings, broken down into north and south Jersey, will be very informal and solely for the purpose of establishing rapport in their role as Carrier for Part B of the Medicare Program. Component societies were, therefore, urged to accept the invitation of Prudential.

(4) *Instructed Delegates*

Question was asked whether or not a county delegate to the state annual meeting has the privilege of casting his own vote once he has been specifically instructed by the component society. Legal Counsel explained that this is not covered in the MSNJ Bylaws but could be covered in the bylaws of individual component societies. It was his opinion that, once instructed by a component society, a delegate has the moral obligation to cast his vote as directed by the organization which he represents. If a member does not abide by his county's directive, he can always be replaced as a delegate the following year, or when his term expires.

(5) *Medical Student Loan Fund*

In behalf of his component society, the President of the Camden County Medical Society presented a $1,000 bicentennial memorial donation to the Medical Student Loan Fund. It was noted that this is the largest contribution so far to the special memorial fund.

(6) *Title XIX: Medical Assistance*

Distributed to those present was a reprint from JAMA (January 10, 1966) outlining public law 89-97. This explanation was offered to component societies as one of the most concise and lucid explanations available. Copies were later mailed to the presidents of those societies which were not represented.

(7) *Future Meetings*

Those present unanimously agreed that the meetings continue to be successful and profitable and should be continued — at least twice a year.

In behalf of the Board, the chairman urged the members freely to make any other comments or to raise any other questions. There being none, this portion of the meeting was brought to a close. County presidents were invited to remain for the remainder of the meeting, if they so desired.

Liability Insurance . . . Approved the following recommendations of the Committee on Medical Defense and Insurance, for submission to the House of Delegates:

(1) That the American Mutual Liability Insurance Company be continued as the officially designated carrier for our professional liability insurance program.

(2) That the E. & W. Blanksteen Agency be continued as the official broker for our accident and health, high-limit accident, major medical, and life insurance programs.

General Session on Medicare . . . Revised the General Session on Medicare (Sunday, May 15) to accommodate as one of the panelists a representative from the Prudential Life Insurance Company, to explain to the members what they should know about Medicare "from the viewpoint of the carrier."

Delegates Luncheon . . . Authorized a one-hour luncheon recess for the third session of the House (Wednesday, May 18), with sandwiches and coffee available for all delegates.

Bicentennial Flower . . . Authorized — in response to a specific request — that the name of the first president of MSNJ be applied to a dahlia, in commemoration of the Society's bicentennial (Dr. Robert McKean Dahlia).

Home Care . . . Appointed Dr. Matthew E. Boylan of Jersey City to serve as the Society's official liaison representative for operations in conjunction with the Home Care program.

Osteopathic Physicians . . . Authorized a letter to New Jersey's two United States Senators, apprising them of MSNJ's action supporting a protest from the Camden County Medical Society that osteopathic physicians have not yet been drafted in the armed services.

Woman's Auxiliary . . . Received with appreciation a commitment from the Woman's Auxiliary to staff the Bicentennial History Exhibit booth at the forthcoming annual meeting.

Public Health Conference . . . Agreed to co-sponsor with the New Jersey Public Health Association its annual spring conference.

Bicentennial Contribution . . . Reconsidered, at the request of the Chairman of the Medical Student Loan Fund, its action of February 20, as follows:

That any component society making a bicentennial commemorative contribution which amounts to $1 or more per member be recognized by the inclusion of its name on the ($500) plaque.

. . . Rescinded the foregoing action, for the following reasons:

a. The original request for commemorative contributions to the Medical Student Loan Fund was made in good faith with more than 200 people: presidents of all component societies, presidents of all county auxiliaries, and major pharmaceutical houses throughout the state. This solicitation resulted in an appreciable number of contributions on that basis. The original letter of solicitation specifically designated that "the donors of $500 or more will be inscribed on a plaque to reside permanently in the Executive Offices of this Society."

b. The action of the Board as adopted would require larger component societies to make a contribution in excess of $500 in order to be included on the plaque. Such requirement would likewise be in contravention of the original intent of the solicitation letters.

. . . Authorized an additional laminated plaque, on which will be recorded the names of all those giving $100 or more, not eligible for inclusion on the bronze plaque.

February 20, 1966

A regular meeting of the Board of Trustees was held at the Executive Offices on Sunday, February 20, 1966. Here is a summary of the significant actions.

Prudential Insurance Company . . . Accepted the invitation from Prudential Insurance Company to a dinner meeting in Newark to establish rapport and cooperation as carrier for Part B of Medicare.

Governor's Committee on Blue Cross Costs . . . Named the following as official representatives of MSNJ to attend a session of the Governor's committee dealing with the doctors' role in controlling hospital costs: Drs. Nicholas A. Bertha, Joseph P. Donnelly, David Eckstein, Nicholas E. Marchione; and Richard I. Nevin.

Medicare Program . . . Approved the requests of the Social Security office that MSNJ cooperate in a mailing to all members, to solicit and help in encouraging patients over 65 to sign up for the voluntary professional services coverage under Part B of Medicare.

Hospital-Nursing Home Conference . . . Authorized Dr. David Eckstein of Trenton to attend, as the Society's official representative, the Fifth Annual Hospital-Nursing Home Conference to be held at the Brunswick Inn on April 20.

Press Clipping Service . . . Approved the recommendation of the Council on Public Relations that the clipping service be reinstated April 1, in conjunction with the Bicentennial celebration.

Official Photographer . . . Approved the recommendation of the Council on Public Relations that an official photographer be engaged by the Society to record the activities of the Bicentennial convention in Atlantic City; named Central Studios of Atlantic City as the official photographer; accepted the following terms outlined by Central Studios:

a. MSNJ will not engage any other photographer or studio to take pictures during the duration of the convention in Atlantic City. This does not exclude picture-taking by members and newspapers for their own use. However, pictures taken under these circumstances may not be offered for sale.

b. The official photographer will be permitted to check with exhibitors at the convention and be engaged personally by them to take pictures of their booths.

c. The official photographer will be permitted to take informal photographs at all social functions, and to display and sell such pictures on an individual, personal basis.

Drug Addiction . . . Approved the following report of the Council on Public Relations arising from the action of the Society's 1964 House of Delegates "that MSNJ engage in a state-wide educational program to prevent drug addiction in conjunction with our law enforcement agencies:"

The council unanimously concluded that the educational program called for in the resolution could be broken down into two aspects: (1) such education as may be achieved with members of the medical profession, and (2) such education as may be achieved with members of the public. To this end, the council unanimously adopted the following *recommendations*:

Education as may be achieved with members of MSNJ

(1) Encourage members to adhere to all requirements concerning the treatment and reporting of narcotic addicts.

(2) Urge members, as a cooperative gesture, to assume responsibility for reporting ambulant patients who may request drugs to alleviate pain under suspicious circumstances.

(3) Urge members to be careful about custody of their prescription blanks.

(4) Caution members to write prescriptions in such a way as to prevent their being altered; encourage pharmacists to verify with physicians any prescription which they suspect as having been altered.

Education as may be achieved with members of the public

(1) MSNJ make representatives available to the State Departments of Education, of Health, and of Law and Public Safety, and any other agencies which may cooperate in evolving an educational program, to be used on a pilot-study basis, in which physicians can participate.

Received the following report of the Council on Public Relations in dealing with the recommendations of the Subcommittee on Narcotics of the Council on Public Health, and took the actions indicated:

The council reviewed the following recommendations of the Subcommittee on Narcotics of the Council on Public Health:

a. The State's present program should be implemented and encouraged to the fullest. Additional personnel and facilities should be made available as needed from less pressing tasks. The technical questions relative to the use of Methadon should be reviewed by the State Department of Institutions and Agencies.

The council is disposed to concur in this recommendation, subject only to the development of sufficient conclusive experimental data concerning Methadone to serve as a basis for judgment.

b. Provisions for follow-up and outpatient care should not utilize Probation Officers. This is a medical problem. Most addicts are concentrated in a few densely populated areas. Existing or augmented existing facilities in these areas should be employed. State financial support of the facilities may be needed.

The council could not support this recommendation, because it is impracticable. Such individuals as are involved have been convicted in courts of law and are, therefore, under jurisdiction of the courts. As criminals under suspended sentences, they are on probation and subject to the supervision of probation officers. This MSNJ is powerless to change. Probation officers are not utilized for individuals not assigned to them by the courts.

c. Private physicians under careful rules should be encouraged to treat addicts either as state or private patients. A well-rounded program of counselling, therapy, and medication is required. The incurable patient may require sustaining doses of drugs to keep him from desperate acts. He is a sick person, dependent on drugs as the diabetic is on insulin.

d. The interpretation of the Harrison Narcotics Act brings the treating physician into conflict with the Narcotics Bureau so that many or all of the recommendations under paragraph c above may be considered illegal by them. Therefore the interpretations should be reevaluated in the face of present day knowledge and the enlarging problem. Prompt action by the Trustees is recommended.

The council felt that it had not sufficient knowledge or authority to act on these controversial recommendations.

The Board approved the action of the council on the basis that it has not sufficient knowledge or authority to act on these controversial recommendations, and referred the matter back to the Subcommittee on Narcotics of the Council on Public Health for continued and extended study.

Child Health . . . Approved the recommendation of the Special Committee on Child Health that a questionnaire be sent to each district school superintendent to obtain information on health studies, including sex education in the schools, grades 1 through 12.

Bicentennial History . . . Approved the final figures submitted for printing of *The Healing Art,* and authorized the total overall cost of $35,064.55.

Membership Directory . . . Approved a price of $7.50 for the 1966-67 directory, except for hospitals and members who request an additional copy; agreed to follow the same format as the 1964-65 issue, with the addition of thumb index for counties and bold-faced type for identification of type of practice; agreed to carry staff listings of proprietary hospitals whose staff members are members of MSNJ; selected Printing Corporation of America as printer; and authorized an anouncement in THE JOURNAL, urging members to submit their listings as early as possible.

Public Health Association . . . Designated Dr. Louis K. Collins of Glassboro as MSNJ's official representative to the planning committee for the annual spring conference of the New Jersey Public Health Association.

AMA Citation . . . Accepted with pleasure a scroll from the American Medical Association, commemorating the Bicentennial of MSNJ.

Abortion . . . Referred to the Committee on Maternal and Infant Welfare a resolution from the New Jersey branch of the American Medical Women's Association, Inc., urging MSNJ to take action which would result in legislation to expand state laws governing abortion.

Executive Offices . . . Approved the recommendations of the Special Committee on House Maintenance, Staff Policies, and Personnel Relations, as follows:

1. That baseboard heating in the board room be installed at a cost of $285.00.

2. That aluminum vertical venetian blinds be purchased and installed in the auditorium at a cost of $225.00.

Dues Exemption . . . Directed that the dues be refunded on a pro-rata basis to any member drafted into the armed services after paying his dues.

Sesquicentennial Celebrations . . . Agreed to award to the five component societies celebrating their sesquicentennials in 1966 a citation similar to that received by MSNJ from the AMA.

Good Form For Medicare

A special "Subcommittee on Forms" of the AMA technical advisory committee has recommended a claims form to be used under Part B, the Supplementary Medical Insurance Benefits portion of the Medicare Law. Initially, HEW had prepared 17 different forms for consideration by the subcommittee. These forms, although patterned after commercial insurance forms now in use, contained other material which HEW felt necessary. For example, a form originally preferred by HEW contained a separate page for patients to complete and a separate page which would be completed by physicians. Accompanying these forms would be some 8 pages of instructions as to how they were to be completed.

At one time, there seemed to be little hope of resolving the differences between HEW and representatives of the various groups on the proper forms to be used. At this point, the chairman of the AMA physician contingent submitted a one-page, two-part claims form which received acceptance from the members of the subcommittee and HEW. This form, with minor changes as recommended by the subcommittee and SSA, is reproduced on the following page.

The one-page, two-part claims form, to be used in the administration of the Part B Supplementary Medical Insurance Benefits portion of the Law, requires only minimal information. The patient need do little more than sign the form which authorizes the physician to send the required medical data to the Social Security Administration. The physician is asked briefly to describe the conditions treated and the service rendered, along with charges. Complete instructions for the beneficiary and the physician (or supplier) are contained on the reverse side of the form.

The form has been reviewed by the Health Insurance Benefits Advisory Council, Blue Cross-Blue Shield, the insurance companies, and representatives of the medical profession. No major modifications have been recommended, and it seems likely that this form will approximate the final version which will be utilized in the implementation of Part B of Public Law 89-97.

"Pap" Smear Kits For Your Use

Since 1948 the New Jersey Division of the American Cancer Society, in cooperation with the New Jersey Society of Clinical Pathologists, has attempted to stimulate complete physical examinations, including "Pap" smears, for the early detection of cancer. New Jersey was a pioneer in this. It is no exaggeration to say that many New Jersey lives have been saved by early cancer detection.

To stimulate greater use of the "Pap" smear, the New Jersey Division of the American Cancer Society has purchased an initial supply of "Pap" smear kits for physician use. Each kit contains Spray-Cyte, slides, mailers, scrapers and instructions. It is worth $5.00. One kit will be sent gratis to each New Jersey physician requesting it for his private practice.

The New Jersey Society of Clinical Pathologists is cooperating in this. The New Jersey Division is alerting the public to the importance of the "Pap" smear and foresees an increased demand for it. Make yourself available to respond to the increased number of requests for "Pap" smears.

To get your free "Pap" smear kit, write to the N. J. Division of the American Cancer Society at 621 Central Avenue, Newark 07107, and ask for it.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved.
Budget Bureau No.

REQUEST FOR PAYMENT

MEDICAL INSURANCE BENEFITS (Title XVIII, Social Security Act)

MAILING INSTRUCTIONS: Complete this form in accordance with the instructions on the reverse and mail it to the insurance carrier designated to handle your medical insurance claims under Medicare.

HEALTH INSURANCE CARD INFORMATION (Copy from Card)
NAME OF BENEFICIARY

CLAIM NUMBER | SEX

IS ENTITLED TO: | EFFECTIVE DATE
HOSPITAL INSURANCE
MEDICAL INSURANCE

PATIENT COMPLETES

PART I – PATIENT CLAIMS STATEMENT AND AUTHORIZATION

1. Describe the illness or injury which required treatment. If your illness or injury arose out of your employment, also give the name and address of your employer. *(Not necessary to complete this Item if the physician completes Item 4D. of Part II below.)*

2. PATIENT'S STATEMENT—The above information is correct. I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services described. I understand that I am responsible for any charges which are not covered.

I authorize release of any information required to act on this claim and permit a photographic reproduction of this authorization to be used in place of the original.

PATIENT'S ASSIGNMENT—If patient desires to assign payment for an unpaid bill, he should check here → ☐
(A separate "Request for Payment" form must be used for each assignment accepted by a physician or supplier of services.)

Date | Signature of Patient or his Representative

3. PATIENT'S MAILING ADDRESS *(Street address, City, State, ZIP Code)*

PHYSICIAN OR SUPPLIER COMPLETES

PART II – REPORT OF SERVICES OR SUPPLIES

4. A. DATE(S) SERVICES OR SUPPLIES WERE FURNISHED	B. PLACE OF SERVICE O-OFFICE, H-HOME, HOSP-HOSPITAL, NH-NURSING HOME	C. DESCRIBE PROCEDURES, SERVICES OR SUPPLIES FURNISHED *(Use reverse side, if necessary)*	D. NATURE OF INJURY OR ILLNESS REQUIRING SERVICES OR SUPPLIES *(Diagnosis)*	E. CHARGES
				$
				$
				$
				$
				$
				$

CLEARANCE COPY

☐ If condition is employment related, check here.

TOTAL CHARGES → $

5. ☐ I hereby accept assignment in accordance with Section 1842(b)(3)(B)(ii) of PL 89–97.
☐ I do not accept assignment.

6. Amount of total charges paid. $ _____
Balance due $

7. DATE SIGNED | 8. SIGNATURE OF PHYSICIAN OR SUPPLIER | ☐ DO ☐ MD ☐ DDS

9. PRINT OR TYPE NAME OF PHYSICIAN OR SUPPLIER *(If organization, give its full name)* | 10. ADDRESS OF PHYSICIAN OR SUPPLIER *(Street address, City, State, ZIP Code)*

FORM SSA-1490 (1-6-66) PHYSICIAN'S OR SUPPLIER'S COPY

INSTRUCTIONS

The $50 deductible is based on your medical expenses during each calendar year. As you incur expenses, bills covering the deductible may be submitted with this claims form to the insurance carrier handling your insurance under Medicare. Your carrier will send you a notice when you have met the deductible.

A claim can be filed in two ways:

1. You can request that payment be made to you if you have paid the medical bill being submitted. Bills cannot be returned.
2. If the physician or other party furnishing medical services or items agrees, you may assign the right to receive payment for such unpaid medical bill. If you assign payment, you should check the box in Item 2, Part I. The person accepting your assignment should check the box in Item 5, Part II to show he accepted your assignment.

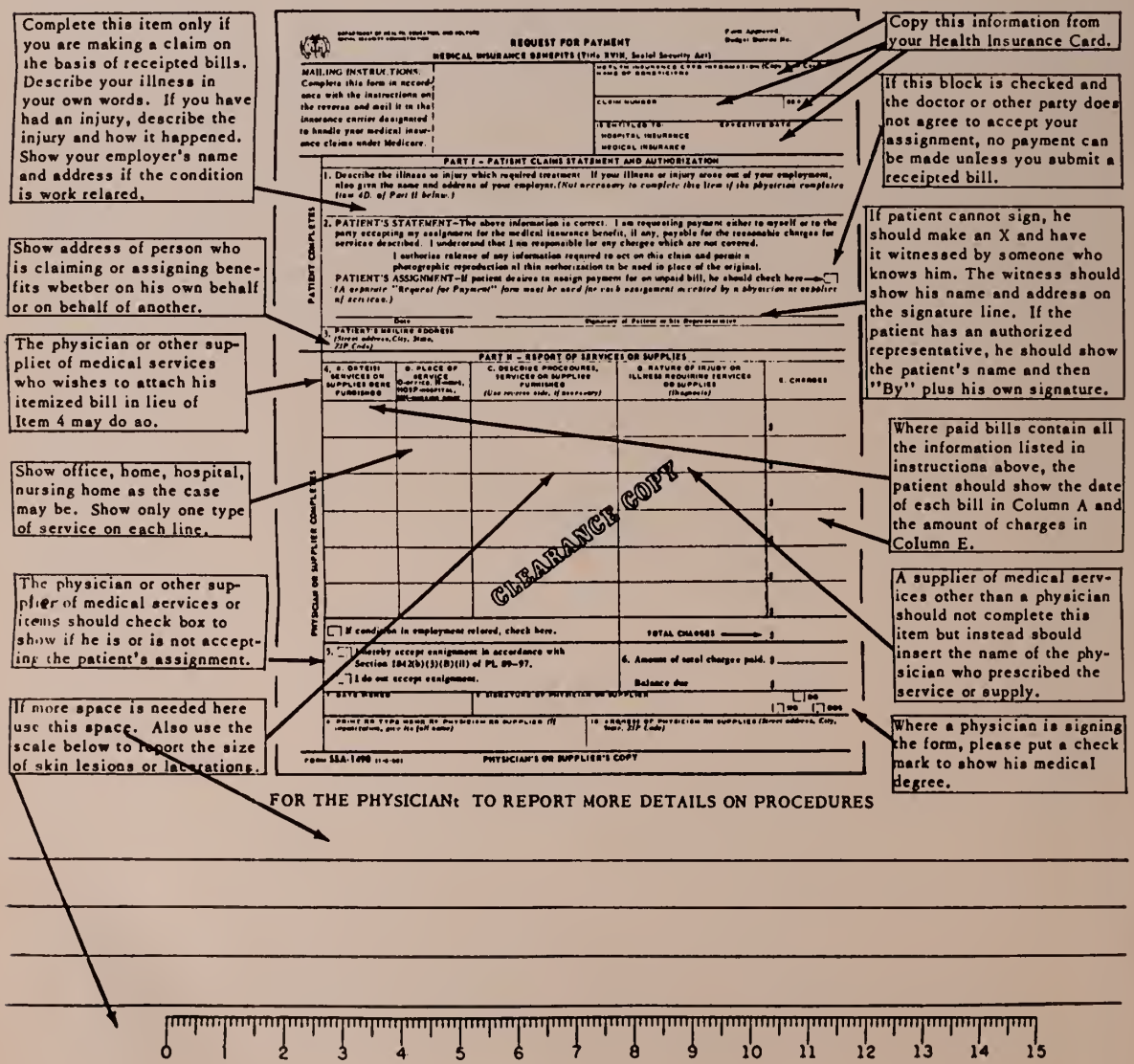
You are responsible for any non-covered charges.

Any questions as to how to complete and where to mail this form, should be directed to the patient's Social Security Office.

If you are submitting receipted paid bills, each bill should contain this information:

- Name of person or organization providing the medical services or supplies. If not furnished by a physician, the name of the physician prescribing the services or supplies should be shown.
- Name of patient receiving the services or supplies.
- Each date the services or supplies were provided.
- A description of the medical services or supplies furnished.
- The charges for each medical service or item supplied.
- The receipt showing the bill was paid may be on the bill or attached to it. Do not submit cancelled checks.

If your bills do not contain the information listed above, the doctor or other supplier of medical services or supplies should complete Part II.



BICENTENNALIA

Thomas Dunn English: Doctor, Lawyer, Author

Among New Jersey's literary figures—Freneau, Whitman, Stockton, Gilder, Van Dyke – two physicians appear: Thomas Dunn English in the past century and William Carlos Williams in the present. Dr. English, cited twice in the latest edition of *Bartlett's Familiar Quotations* (1955), was an energetic man who pursued several professions – medicine, law, literature, politics – achieving contemporary recognition in each. A prolific author, his verse is still connected with the State where he spent most of his years. It is time to reappraise his work and tangibly memorialize this son of the Garden State.

Descended from Quaker ancestors who were early settlers in New Jersey, Thomas was born near Philadelphia on June 29, 1819. After preliminary education at the Friends' Academy at Burlington, he received his M.D. degree from the University of Pennsylvania in 1839 at the age of twenty. His doctoral thesis had as its subject phrenology, the now obsolete study of the mind and character from the shape of one's skull.

Following a brief medical practice, Dr. English studied law and was admitted to the bar at Philadelphia in 1842. Early attracted to journalism, he met Edgar Allan Poe, then an editor in that city. In 1844 the Doctor moved to New York City where he edited a newspaper, the *Aurora,* and a literary magazine, the *Aristidian,* to which both Poe and Walt Whitman were contributors.

Returning to Philadelphia in 1848, English founded a humorous periodical entitled *John Donkey,* but libel suits stilled its braying after several months. Not forsaking science, in 1851 he edited and contributed several papers to a short-lived medical journal, *The Philadelphia Lancet.*

In the next year (1852), Dr. English returned to active practice of both law and medicine at Logan, West Virginia. In addition, he became the first mayor of that town. Three years later he settled in New Jersey, his home for the remaining forty-five years of his life.

Practicing medicine at Fort Lee and Hackensack during the Civil War, he was, for a time, a member of the New Jersey Legislature from Bergen County. While at Fort Lee he wrote a plea for the preservation of Revolutionary War ruins overlooking the Hudson River at that site. Continuing public activity after moving to Newark in 1878, he was elected to Congress and served from 1890 to 1894.

A voluminous writer, English produced many poems, several novels and plays, numerous editorials, legal and political documents. Being primarily concerned with contemporary events, his style was hurried and generally more charming than profound. Romanticism, the dominant strain of the nineteenth century, appears throughout his writings. His nostalgic poem, *Ben Bolt,* written in 1843, became very popular throughout the English speaking world.

Oh! don't you remember sweet Alice, Ben Bolt?
Sweet Alice, whose hair was so brown,
Who blushed with delight when you gave her a smile,
And trembled with fear at your frown?

Ben Bolt catapulted Dr. English to literary fame. The adulation resulting from this ditty came to annoy its author, however, and he spoke slightingly of its worldwide success. At a meeting of the Essex County Medical Society (of which he was a member) a quartet appeared on one occasion to sing it in his honor. Obviously displeased, the doctor threatened to leave the gathering if the song was not promptly discontinued! More recent-

ly, Carl L. Carmer, in his folklore collection, *Songs of the Rivers of America* (1942), chose *Ben Bolt* as typifying the spirit of the Delaware River.

In his nature verses, English left us vivid descriptions of our country's natural beauty. His "rural idyls" reveal a fine appreciation for American landscapes. *The Delaware* ranks among the best in this class.

Down through the hills and through the valleys that glow
With the sun from above and the green from below,
On by the cities that lie at my side,
Growing deeper and wider, I quietly glide
Past where the Schuylkill pays tribute to me,
Till I reach in my journey the fathomless sea.

There where the ships from the North and the South,
And the East and the West, with their keels vex my mouth,
I mingle my waters with those of the main,
Bury my flood in the flood of the ocean,
Whose motion repels me again and again,
Yet flowing and flowing.

Through his folk ballads (published in book form as *American Ballads* in 1879) Dr. English made his most significant contribution to our national heritage. These ballads exhale the fragrance of an age which was far less complicated than our own. Human sympathy and insight appear amid experiences common to all. In *Betty Zane*, for example, we read:

Though little dangers they may fear,
When greater dangers men environ
The women show a front of iron;
And, gentle in their manner, they
Do bold things in a quiet way.

Married to Annie Maxwell Meade of Philadelphia in 1856, Dr. English fathered four children. A daughter, Alice, collected much of her father's verse in a volume, *The Selected Poems of Dr. Thomas Dunn English* (1894). Three years later, another daughter, Florence English Noll, edited his *Fairy Stories and Wonder Tales;* and in 1904 his son-in-law, Arthur H. Noll, brought out a similar volume culled from periodicals.

In recognition of his varied achievements, the College of William and Mary in Virginia in 1876 conferred an honorary doctoral degree upon Dr. English. Returning to journalism late in life, he served on the literary staff of the *Newark Sunday Call* prior to his death on April 1, 1902.

Fred B. Rogers, M.D.

OBITUARIES

Dr. Howard R. Dukes

One of America's pioneers in open heart surgery, Dr. Howard R. Dukes, died on February 25, 1966. Born in Harrison (N.J.) in 1889, Dr. Dukes earned his M.D. at Bellevue in 1912. During World War I, he was a captain in the medical corps of the Army of the United States. After a busy and successful surgical practice in Hudson and Essex Counties, Dr. Dukes retired and became an emeritus member of The Medical Society of New Jersey.

Dr. Eugene M. Kiely

While attending a religious ordination in Virginia, Dr. Eugene M. Kiely died of an acute coronary attack on March 5, 1966. Born in 1904, Dr. Kiely received his M.D. at Georgetown in 1929. He was a general practitioner with special interest and training in obstetrics and gynecology. An FACS, Dr. Kiely was attending obstetrician and gynecologist at St. Mary's Hospital in Hoboken. He was active in affairs of the Hudson County Medical Society.

Dr. Edward V. Padney

One of Jersey City's senior police surgeons, Dr. Edward V. Padney, died suddenly on February 13, 1966 at the age of 58. Dr. Padney received his baccalaureate degree at Georgetown, and in 1932, was awarded his M.D. there. He returned to his native Jersey City for internship at the Medical Center, and he served the people of Hudson County for the rest of an active professional life. Although Dr. Padney was proud to be called a general practitioner, he was, in fact, one of the earliest to get special training in radiology and roentgenology. He was active in many fraternal organizations including the Policemen's Benevolent Association. While others, it was said, were deserting the down-town areas of our large cities, Dr. Padney never wanted to work anywhere else. There he was born, raised, practiced, and died.

BOOK REVIEWS

Respiratory Care. H. H. Bendixen and others of the Respiratory Unit at the Massachusetts General Hospitals. St. Louis, 1965, Mosby. Pp. 252 with many illustrations, graphs and diagrams. ($15.)

In a concise manner, the authors have reviewed advances in respiratory physiology and have applied this knowledge to clinical use. They have shown that with proper equipment, facilities, and clinical acumen the high morbidity and mortality from respiratory complications can be markedly decreased. The book starts with such fundamentals as the relationship of ventilation to perfusion and physiologic considerations of respiratory insufficiency. These chapters are well illustrated with graphs, charts, and diagrams.

The second part of the text relates to the diagnosis of respiratory failure, blood-gas measurements, and acid-base balance. In reading these chapters the clinician will think he is back in medical school. Then the authors suggest how to prevent respiratory complications, chest physical therapy, and the needs of humidification. The chapter on chest physical therapy is well illustrated, showing positioning and methods.

The remainder of the text discusses the clinical application of respiratory physiology—that is, a "therapy." The authors have based these methods and results on their experience at the Massachusetts General Hospital. Case histories are included.

This easy to read text should be required reading for all residents in medicine or surgery. The clinician will also find this book a valuable addition to his library.

Wilbur F. Jehl, M.D.

Sociologic Aspects of Homosexuality. Michael Schofield. Boston, 1965, Little Brown. Pp. 244. ($10.)

Homosexuals, Schofield finds, got into trouble not because of any inherently degenerate traits, but because the pressures of society make it impossible for them to live openly and legally. They are thus forced into an alienated world of their own. The author rejects any biologic, genetic, or endocrine factors; and, indeed, believes it is nonsense to label homosexuality a "disease" at all. It is, admittedly, a deviant interest and aberrant behavior. But nonconformity is not to be branded as sickness. Schofield's survey shows a marked difference between the homosexual who involves himself with children and the one whose target is a consenting and knowledgeable adult. Compared with the latter, the pediophile is likely to be older, to maintain a high religious or sanctimonious moral tone, to shun the company of other homosexuals, and to be filled with a sense of guilt or shame.

This British-authored work is a smoothly-written, carefully researched study of the social factors that go into the making and misery of the homosexual. Schofield's attitude is that this is a problem only because an unsophisticated and guilt-ridden society pushes the deviate into the ranks of outcasts. His text contains several constuctive suggestions — not for curing or eliminating homosexuality, but for making it a less troublesome problem. There is much wisdom as well as compassion here.

Henry A. Davidson, M.D.

Pediatric Therapy. 2nd Edition. Edited by Harry C. Shirkey, M.D. with 84 contributors. St. Louis, 1966, Mosby. Pp. 1222. Illustrated ($18.50)

In all medicine, diagnosis may enchant the physician, but the real pay-off is treatment. So when this book first came out in 1963, it was hailed as a really practical manual for GP's and pediatricians. This new edition brings it up to date. A table of drug dosages on colored pages near the back of the book further enhances the usefulness of the text. Also included is a section on recognizing and handling poisoning in children. The reader will here find information on the treatment of everything from abscesses to Wilms' Tumor. The editor, Dr. Shirkey, is a pharmacist and pharmacologist as well as a physician, and his 84 contributors represent a truly star-studded faculty, not only in pediatrics, but in surgery, radiology, ophthalmology, psychiatry, neurology, and other medical disciplines. This fat volume will soon earn its shelf space in any pediatrician's office.

Ralph Neil Shapiro, M.D.

Twins: Twice the Trouble, Twice the Fun. By Betsy Holland Gehman. Philadelphia, 1965, J. B. Lippincott Company. Pp. 224. ($4.95)

At least "twice the trouble" one feels after reading this chronicle by a mother of twins. But the reading is "fun," thanks to the refreshing humor of the author who bore twins two years after constantly wearing bowler hats, believed by Bolivian women to increase the chance of twin pregnancy. Mrs. Gehman offers us an interesting review of historical and fictional descriptions of twins, followed by solid factual background about twin pregnancies including "Twin Insurance" policy rates. The bulk of the book is devoted to detailed advice to the mother who hasn't the ideal solution ("ten arms; Oh, joy!") regarding ways to cut the work load and best handle the management of two at once. Some of this is redundant but helpful to the mother with previous children; for the inexperienced mother, it is invaluable.

Interesting selected interviews with twins and parents of twins are provided, giving an excellent presentation of the different viewpoints and ramifications of the adjustment problems. The major theme stresses the need to treat each child as an individual. This test is recommended as enjoyable and informative reading for prospective mothers of twins — and with its help they should have "twice the fun."

J. B. Skelton, M.D.

Illegitimacy. Several authors, prepared by the National Council on Illegitimacy, New York, 1965. Pp. 64. Paper-back. ($1.65)

The National Council on Illegitimacy is a little-known organization set up to develop services for unmarried parents and their children. It is affiliated with the Child Welfare League of America. This pamphlet is a compilation of essays by social workers, sociologists, physicians, and psychologists on social attitudes towards the problem, on factors that seem to be increasing the illegitimacy rates, and even on the usually neglected partner — the unmarried father. Possible control measures are also suggested.

Victor Huberman, M.D.

Closing the Gap Between Medicine and Psychiatry. Wilfred Dorfman, M.D. Springfield, Illinois, 1965, Charles C. Thomas. Pp. 210. ($8.50)

The interdependence of mind and body is obvious to all, except perhaps to a few unreconstructed psychodynamicists. But this interrelationship is more talked about than acted upon. Every surgeon, family doctor, and gastro-enterologist will concede that emotional factors play a role in peptic ulcer. Not many, however, will bring in the psychiatrists as a team member in "managing" the patient. The gap between the two kinds of healer remains. Rising interest in psychosomatics may, indeed, have made the gap wider because many doctors assume that a psychosomatic explanation means a "psychic" interpretation of symptoms.

In this highly readable and wittily written little book, Dr. Dorfman reviews several physiologic systems and illuminates the emotional components of structural change. The psychosomatic aspects of obesity, arthritis, and allergy are discussed. Also included is an interesting chapter on the pharmacology of antidepressants and tranquilizers in treating emotional and somatic illnesses. A brief text on evaluating depression occupies most of a chapter confusingly called "principles in the management of emotional illness."

Dr. Dorfman does not neglect the other side of the coin — the obscuring of structural disease by apparently emotional symptoms. To the psychiatrist or to the medical-surgical specialist, much of the language will appear a bit elementary. It is better, however, to err on the side of clarity than on the side of prolixity. This book will be particularly appealing to clergymen, psychologists, social workers, and others in the nonmedical field who will be helped towards a clearer understanding of the interweaving of emotional, anatomic, and physiologic factors in human disorders.

FLORENCE OBUCHOWSKI, M.D.

Hashish: Its Chemistry and Pharmacology. Edited by G. E. W. Wolstenholme, O.B.E., and Julie Knight, B.A. Boston, 1965, Little Brown and Company. Pp. 96, Illus. ($2.95)

Hashish is the resin extracted from the hemp plant *Cannabis sativa* — better known in this country as marihuana. This volume is a presentation by experts who comment upon the data of other experts. This approach to the subject (specialists speaking to other specialists) limits its interest for the general medical reader.

Taken on its own terms, however, this volume is useful to those who are conducting research on drug abuse in general and on marihuana in particular. If nothing else, such readers will be gratified to see that the complexities of cannabis study stump the experts, too.

It is revealing to learn how little basis exists for many beliefs about how marihuana affects mental function and behavior. As one contributor puts it, when confronted with data indicating that this drug has reportedly caused every conceivable behavioral change: "I am very much confused!"

Research on hashish has been hampered by a lack of standardization of the material under study. For example, the psychopharmacological effects of cannabis grown in different countries and climates (or even collected in different ways) cannot be compared. Most of the published work has been done on mixtures of more or less unknown constitution and potency. Although a pure principle, tetrahydrocannabinol, is now available, its activity varies, depending on the isomers of which it is made up.

Further complicating pharmacologic study is the low solubility of these compounds in safe solvents, plus the fact that subjecting these substances to combustion by smoking the plant probably alters part of its active constituents. Thus, the ways in which marihuana is handled by the body as well as its central site and mechanism of action are still obscure.

One authority calls hashish "a social evil . . . that causes both pathological and psychic disturbances." Another stresses its harmlessness with, "the psychic habituation to marihuana is not so strong as to tobacco or alcohol." He also points out that habituees have no tendency to increase the dose and that no reaction follows abrupt cessation of drug taking — an indication that there is no physical dependence. Complications, he implies, are caused by pre-existing personality defects rather than by the drug.

Perhaps the most useful thing the reader will get from these proceedings is an insight into how hard it is to collect solid scientific data on drugs and to interpret their significance. Yet, despite these difficulties, the manner in which drug abuse is managed is largely determined not by the findings of scientific medicine, but by the fears of an uninformed public. Legislative bodies, responding to irrational pressures, then pass laws which effectively remove the drug abuser from the province of the physician. MORTON J. RODMAN, Ph.D.

Controversy in Internal Medicine. Edited by Franz J. Ingelfinger, M.D., Arnold S. Relman, M.D., Maxwell Finland, M.D. Philadelphia, 1965, W. B. Saunders Company. Pp. 679. ($14.50)

This well organized book, with its 3 editors and 72 contributors, presents a unique approach to the many differences of opinion on etiology and treatment of diseases and the problems in medicine and surgery with which we are confronted every day. The introduction states: "After all, the airing of controversy has, as its purpose, not merely the exhibition in public of a to-do. It should serve to uncover areas where evidence is lacking, whether in quantity or quality. It should help to force reexamination of all tenets, to test the validity of shibboleths, and to discourage that specious base for so much medical dogma, 'it is generally acknowledged that'." And this objective it most certainly achieves.

Among the 21 controversies aired in this book are such intriguing ones as "Why Have Boards of Internal Medicine?", "Atherosclerosis and Diet," "Autoimmunity Disease," "The Anticoagulant Dilemma," "Who Needs Drugs for Hypertension," "The Control of Obesity," as well as "Lies, Damn Lies, and Statistics."

Each section provides one point of view by one author and an opposing (or at least a not similar) one by others, followed by comment by one of the editors. The reader can then draw his own conclusions based upon the facts as presented. Much of this material may be out of date within two or three years, if not sooner. However, at this moment, this book probably presents the best thinking on the subjects treated. In fact, many of these articles may become classic summaries of our present knowledge.

Since *Controversy in Medicine* does not advocate any one course of action, the effect on the physician can only be one of challenge. The reader is forced to see and think about the many facets of each problem and therein lies the greatest value of this excellent book.

ARTHUR BERNSTEIN, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

MAY, 1966 • VOL. XXXIX, NO. 5

Of viruses isolated in 221 upper-respiratory-tract illnesses, rhinoviruses were the most frequently implicated, but fever was most common with infection due to influenza A virus.

ETIOLOGY OF UPPER RESPIRATORY ILLNESS AMONG CIVILIAN ADULTS

In recent years many newly recognized viruses have been implicated as etiologic agents of acute undifferentiated upper-respiratory-tract illnesses in adults. Of these viruses, the rhinoviruses are apparently the ones most commonly isolated in adults ill with the "common cold."

Approximately 60 antigenically distinct serotypes have been recognized. The agents are associated with between 10 and 30 per cent of these mild illnesses in adults. Parainfluenza viruses and respiratory syncytial virus are associated with a smaller proportion, although they are important causes of bronchiolitis, croup, and pneumonia in children. Adenoviruses and coxsackievirus A-21 account for a minor amount of civilian adult respiratory-tract diseases.

Since there is limited information on the prevalence and relationship to disease of individual rhinovirus serotypes, an investigation was made of the relative frequency of rhinovirus infection and the pattern of occurrence of individual rhinovirus serotypes among civilian adults with minor respiratory-tract illness.

A total of 193 persons, who had 221 illnesses, constituted the study population. All were employees of the National Institutes of Health. Specimens were obtained within six days of onset of illness. Virus isolation was attempted from the nasopharyngeal or throat-swab specimens of all patients. Sera, obtained during acute and convalescent phases of illness, were tested by complement fixation.

Rhinoviruses Common

Evidence of virus infection was detected either by virus isolation or serologic response or both in 74 (34 per cent) of the 221 illnesses. Rhinoviruses were recovered more commonly than any other group of viruses and were isolated during most months of the study. Seventeen distinct serotypes were identified from among the 40 rhinoviruses recovered. No one serotype predominated. Nine strains could not be identified. All patients from whom an identified rhinovirus was recovered were tested for homologous neutralizing antibody with the prototype strain of that serotype. In these tests, 22 (55 per cent) of 40 patients from whom a rhinovirus was recovered had a four-fold or greater rise in homologous neutralizing antibody.

The rate of recovery of other viruses varied from 2 per cent to 5 per cent. A single sharp outbreak of influenza A virus infection occurred in January and February 1963. With one exception, influenza A virus was not detected again.

Parainfluenza virus types 1 and 3 infections were detected in 4 per cent and 2 per cent of illnesses, respectively. This majority of parainfluenza 1 infections were detected from November 1962 to January 1963; one additional patient had parainfluenza infection in

MAURICE A. MUFSON, M.D.; PATRICIA A. WEBB, M.D.; HILDA KENNEDY; VIRGINIA GILL; and ROBERT M. CHANOCK, M.D. *The Journal of the American Medical Association,* January 3, 1966.

June 1964. Parainfluenza 3 infections occurred during three different periods of the study.

Herpesvirus was recovered from 3 per cent of the patients tested, a sporadic pattern of occurrence being evident. Infections due to respiratory syncytial virus, parainfluenza virus type 2, adenovirus or coxsackievirus A-21 were uncommon.

Only three patients had evidence of infection with two or more agents. Infection with influenza type B or *Mycoplasma pneumoniae* was not detected.

Fever Rare

Temperature elevation above 99 F occurred in only 15 (7 per cent) of the patients during the course of illness. Except for influenza A virus, the rate of virus recovery from patients with or without fever was similar. Influenza A virus was recovered significantly more often from persons with febrile illness. Recovery rates for a number of viruses did not vary significantly during the first three to five days of illness.

Influenza A2 virus was epidemic in the United States during the winter of 1963, and, except for one case, all infections with this agent in the study population were detected during January and February 1963. The overall rate of infection with influenza A2 virus was only 5 per cent; however, during January and February 1963, 11 (44 per cent) of 25 patients tested had evidence of infection with this virus. Influenza A infection occurred in all age groups.

Primary infection with the parainfluenza viruses occurs in early childhood and is associated with moderate to severe respiratory-tract illness, usually accompanied by fever. Almost all adults possess neutralizing antibody for parainfluenza virus type 3, and most adults have parainfluenza virus type 1 neutralizing antibody.

Parainfluenza viruses have been recovered from adults with naturally occurring upper-respiratory-tract illness. The significance of naturally occurring reinfection is not clear since comparative data are not available from controlled epidemiologic studies which would substantiate an etiologic role of these viruses in adult illness. However, the development of disease in experimentally infected volunteers who possess neutralizing antibody suggests that these agents are capable of producing illness during reinfection. In the present study, parainfluenza virus types 1 and 3 were recovered from 6 per cent of adults with the upper-respiratory-tract illness. It is probable that we have underestimated the potential role of the parainfluenza viruses in adult upper-respiratory-tract disease.

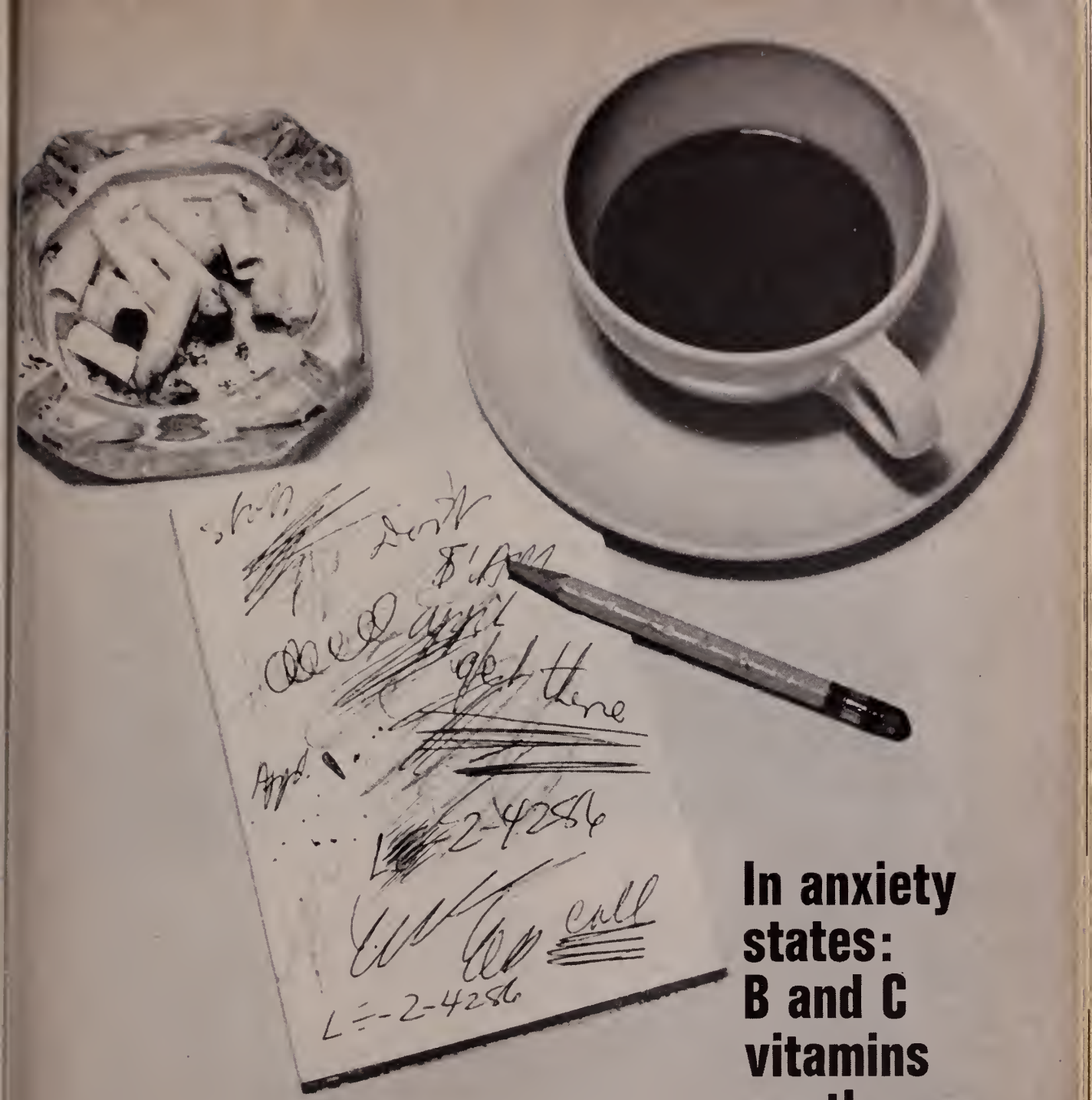
Respiratory syncytial virus resembles the parainfluenza viruses in that primary infection occurs in early childhood and is associated with moderate to severe respiratory-tract illness, often with fever. All or almost all adults possess neutralizing antibody for respiratory syncytial virus. In the present study, evidence of infection with respiratory syncytial virus was found in only two of 221 illnesses.

The relation of herpesvirus infection to naturally occurring upper-respiratory-tract illness in adults is not clearly defined. It has been suggested that herpesvirus is an important etiologic agent of acute pharyngitis in adults.

In the present study, one patient from whom herpesvirus was recovered during two illnesses, one month apart, had an antibody rise following the second illness. This patient lacked complement fixation antibody at the onset of the second illness. These findings suggest that serologic response may not be an adequate measure of primary infection and indicate the difficulty of assessing the role of herpesvirus in naturally occurring upper-respiratory-tract illness in adults.

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DORSEY Season

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Duodenal mucosa with ulcer crater—Approx. 80× Magnification.

Loosening epithelial cells of nasal mucosa during early stage of cold—Approx. 1800× Magnification.

this issue: partners in misery

Partners in misery: common cold and duodenal ulcer*



A century or two ago our forefathers believed that the common cold was caused by an excess of evil humors. Today we regard these baleful humors as a result of the cold rather than its cause. Only in the last ten years have some of the offending viruses been cultivated, and we now know many others can be transmitted to human volunteers although they cannot yet be grown in the laboratory. Various body defenses react to infection by a virus, and in the respiratory tract the lung is protected by the phagocytic properties of the pulmonary alveolar macrophage.[1]

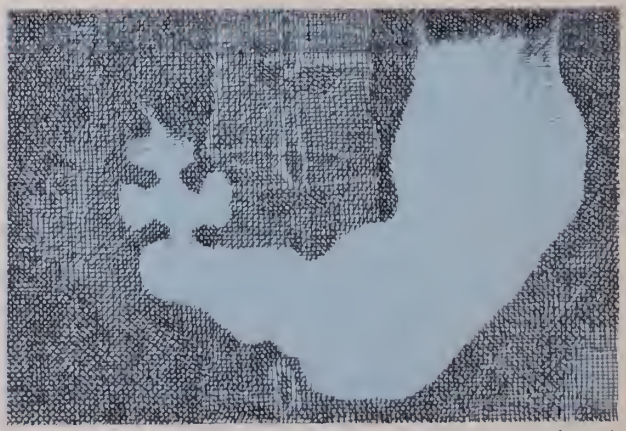
Because of the brief history and large proportion of unidentified viruses, effective prophylactic vaccines have not yet appeared. A universal antiviral agent seems even more remote. Meanwhile, these viruses continue to produce epidemics of upper respiratory infection at seasonal intervals, particularly in spring, fall and winter, during which they propagate and distribute progeny indiscriminately. As a result, they are responsible for significant work loss. Since the immunity afforded is temporary, recurrent infections are common.

This recurrent morbidity in spring and fall is shared by duodenal ulcer, itself a cause of significant loss in wages and medical expense. Thirty years ago Emery and Monroe reported 1,279 recurrences of peptic ulcer of which 13 per cent could be attributed to upper respiratory infection, thus confirming a long-held clinical impression.[2] While the inflammation, congestion and secretion of the mucosa of the nasopharynx in the common cold, and the hyperemia and hypersecretion of the gastric mucosa during acute exacerbation of a duodenal ulcer may not be directly linked, it is probable that the miseries of the infection are reflected in the pain of the ulcer. The following case history illustrates this point.

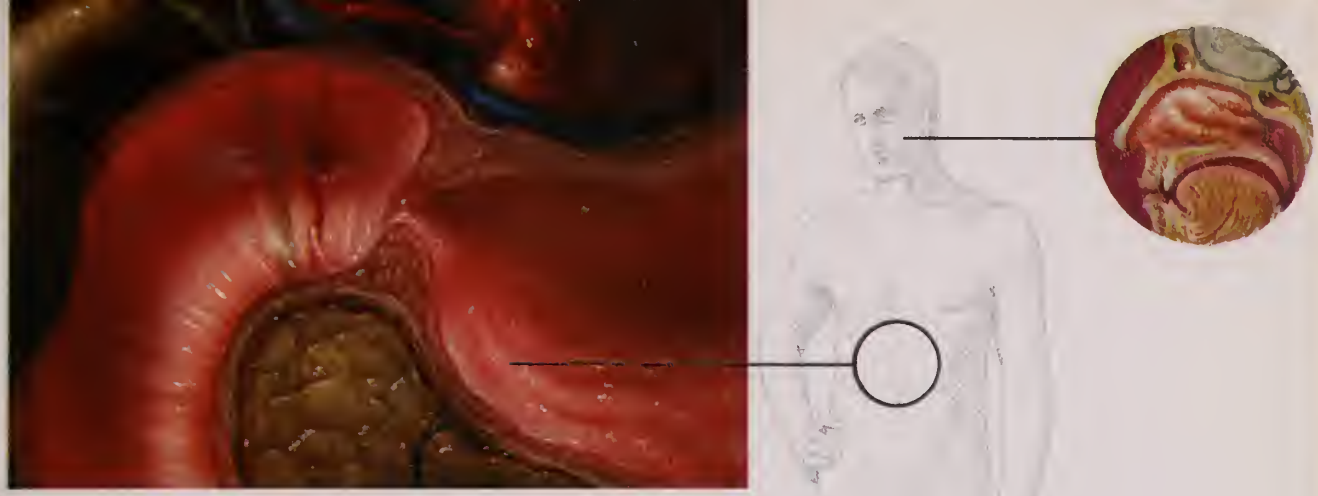
Case report A 48 year old white male executive, suffering from hematemesis and melena for 12 hours was admitted to hospital on April 8, 1965. He gave a history of duodenal ulcer proved by x-ray studies 23 years previously. In the intervening years he suffered from typical epigastric pain occurring two hours postprandially, usually for two or three weeks each spring and fall. A hospital admission two years earlier had followed hematemesis of moderate amount.

The present admission was preceded by a recurrence of pain during a period of unusual business pressure. In addition he caught a cold one week before his entry to hospital and his already irregular eating habits were made more so by loss of taste and appetite, blocked nose and general malaise. During the final 36 hours he used aspirin to relieve his cold, taking 2 or 3 tablets with a glass of water on 6 or 7 occasions. Before retiring he drank a glass of hot toddy.

He awakened about 1 a.m. and vomited dark red blood and recently ingested food mixed with whisky. Melena followed and he was transferred to hospital. On admission he was pale, cold and sweating. Apart from epigastric tenderness and black stool on the examining finger after rectal examination, his general physical examination was not remarkable. Temperature was normal, pulse was thin and thready with a rate of 114 beats per minute, and blood



The commonly found "clover-leaf" roentgenographic abnormality of chronic duodenal ulcer due to spastic contractions and scarring.



Typical site of duodenal ulcer showing anatomical relationship to gastroduodenal artery and common bile duct.

pressure measurement was 104/60mm. of mercury. Hemoglobin estimation was 8.6 grams per cent, but white blood count, chest x-ray and urinalysis were within normal limits. No further bleeding occurred. After blood transfusions and a suitable medical regime he was dismissed two weeks later and advised to return later for consideration of surgery.

The care of the ulcer patient suffering from a viral infection of the upper respiratory tract is additionally handicapped by the local and constitutional symptoms so produced. Indifference to food often makes it difficult to "feed a cold" even in a patient without an ulcer. In the ulcer patient this becomes more than a homily, for malaise and apathy towards irksome routine produce a lack of interest in adhering to an ulcer program and result in its eventual failure if these symptoms are not relieved. The absence of curative treatment for these viral infections has spawned many a strange therapeutic offspring and some of the more generally accepted remedies contain a special risk for the ulcer patient.

To the gastric physiologist, the shot heard around the world was not fired at Concord but was discharged through the stomach of Alexis St. Martin. The worthy voyageur had a more than modest thirst and on several occasions William Beaumont observed through the resulting fistula the changes of gastritis which followed an immoderate ingestion of alcohol.[3] It is now well known that alcohol stimulates the production of gastric juice and the patient with an ulcer, even in remission, should not drink alcohol without first taking food, milk or antacid. The use of various alcoholic remedies for the common cold is to be strongly discouraged in this type of patient. Factors already present can produce an acute exacerbation of ulcer symptoms without the added stimulus of alcohol.

Headache and facial pain, sore throat and generalized aching are subjective discomforts of viral infections of the upper respiratory tract or their complications. Relief from them is usually sought in the family medicine cabinet, and of all the medications habitually stored there, salicylates are the most frequently used. Oral ingestion of salicylates has produced



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substernal pyrosis and sometimes epigastric pain in susceptible individuals. Bleeding from erosions of the gastric mucosa has followed their use and has been severe enough in some instances to cause hematemesis and melena.[4] It has been suggested that interference with the protective mucous layer of the stomach allows this to happen. There is no evidence that hypersecretion occurs, but the taking of aspirin has been followed by exacerbation of ulcer symptoms and occasionally by gastrointestinal bleeding.[5] The ulcer patient with a cold should take salicylates with an antacid, or preferably other means of symptomatic relief should be found.

Caffeine has two actions on gastric secretion. One directly stimulates production of acid and the other potentiates the out-pouring of gastric juice as a response to other stimuli.[6] In high doses to animals, it has produced erosive gastritis and peptic ulceration. Caffeine-containing beverages are discouraged for the ulcer subject and forbidden during an acute exacerbation.[7] Many cold remedies contain caffeine.

To sufferers from allergic rhinitis springtime brings symptoms of nasal obstruction, loss of taste and smell and malaise similar to those caused by viral infection but due instead to allergens which at that time of year are principally tree pollens. Relief from these symptoms can be obtained, though not wisely, by the use of steroid medication. Unfortunately, chronic sufferers from these allergies have used this approach with varying degrees of success. Steroid hormones increase gastric secretion and delay the healing of experimental ulcers.[8,9] Clinically their administration has been associated with reactivation of healed duodenal ulcers, and with bleeding and perforation which were not always preceded by typical ulcer distress. Because of these harmful effects, their use in the ulcer patient is best avoided for other than serious medical problems and then only with adequate antacid coverage.

Summing up It is immaterial by which pathways the malaise and lassitude, depression and irritability activate an ulcer, but it is the physician's responsibility to ensure that the medications he selects to relieve the symptoms of a cold do not further aggravate the ulcer.

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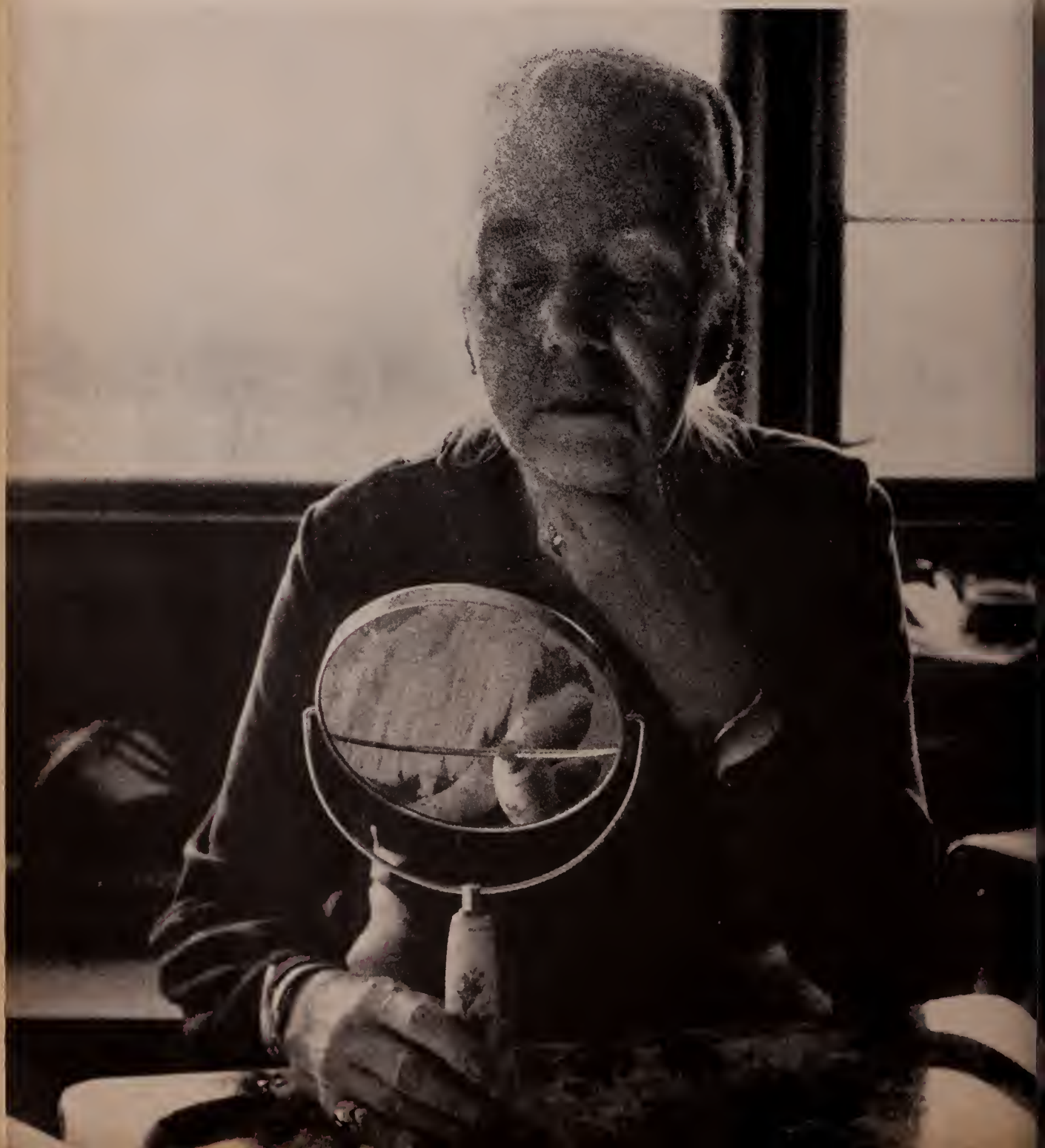
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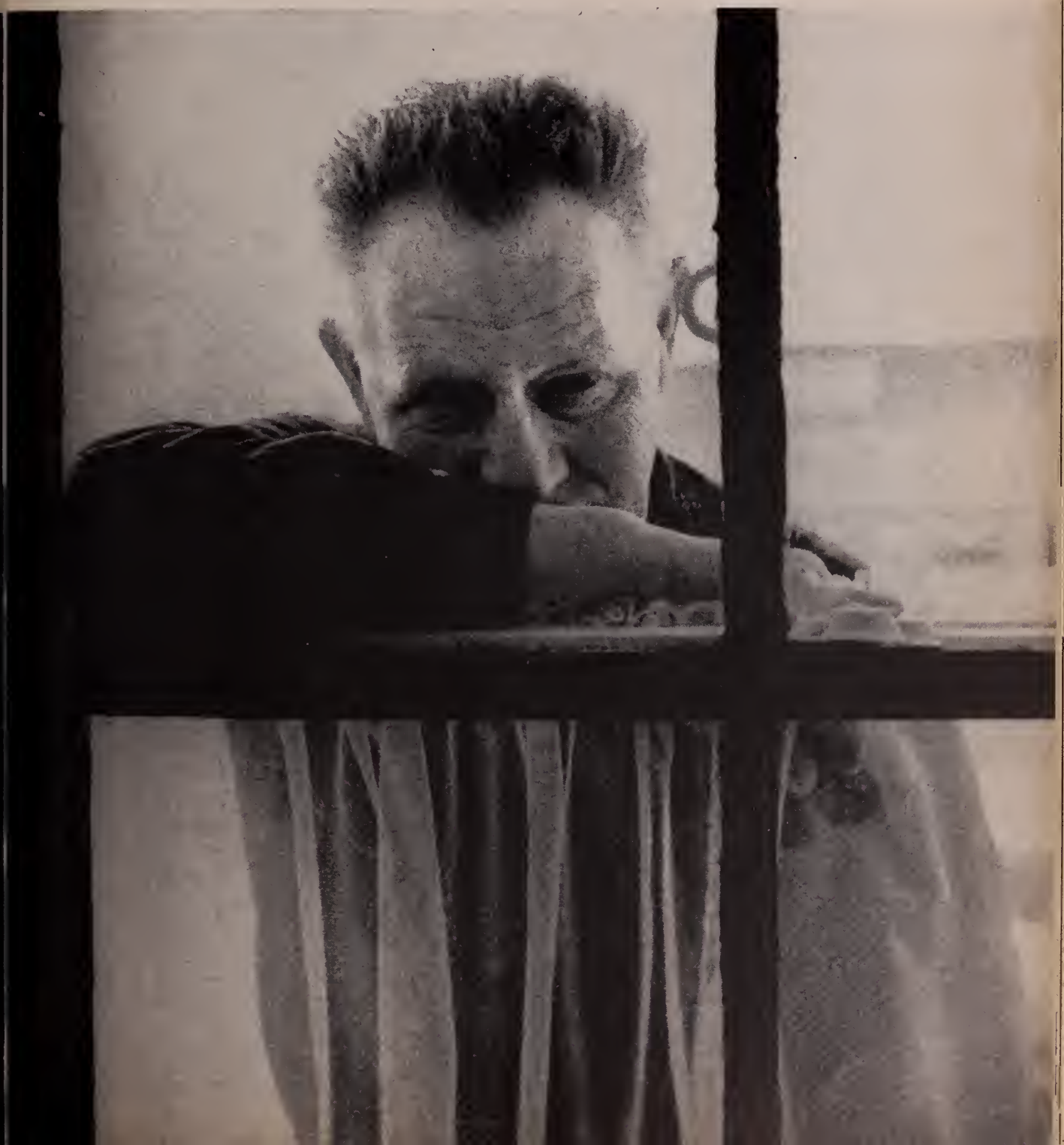
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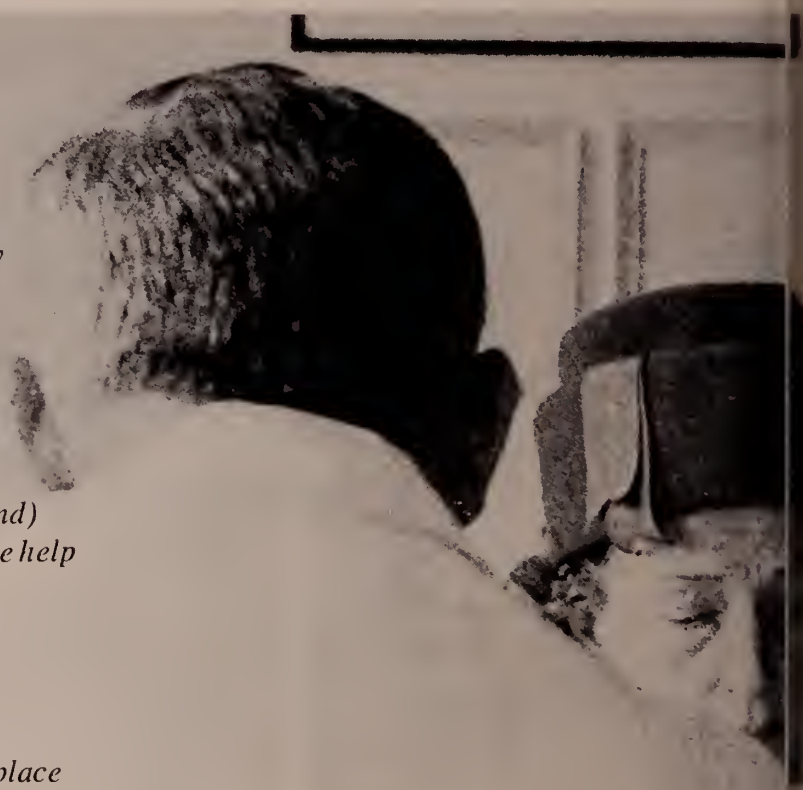


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Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et ol.: Angiology, 12:102, 1961. 3. Rowls, W., et ol.: Med. Times, 87:818, 1959.

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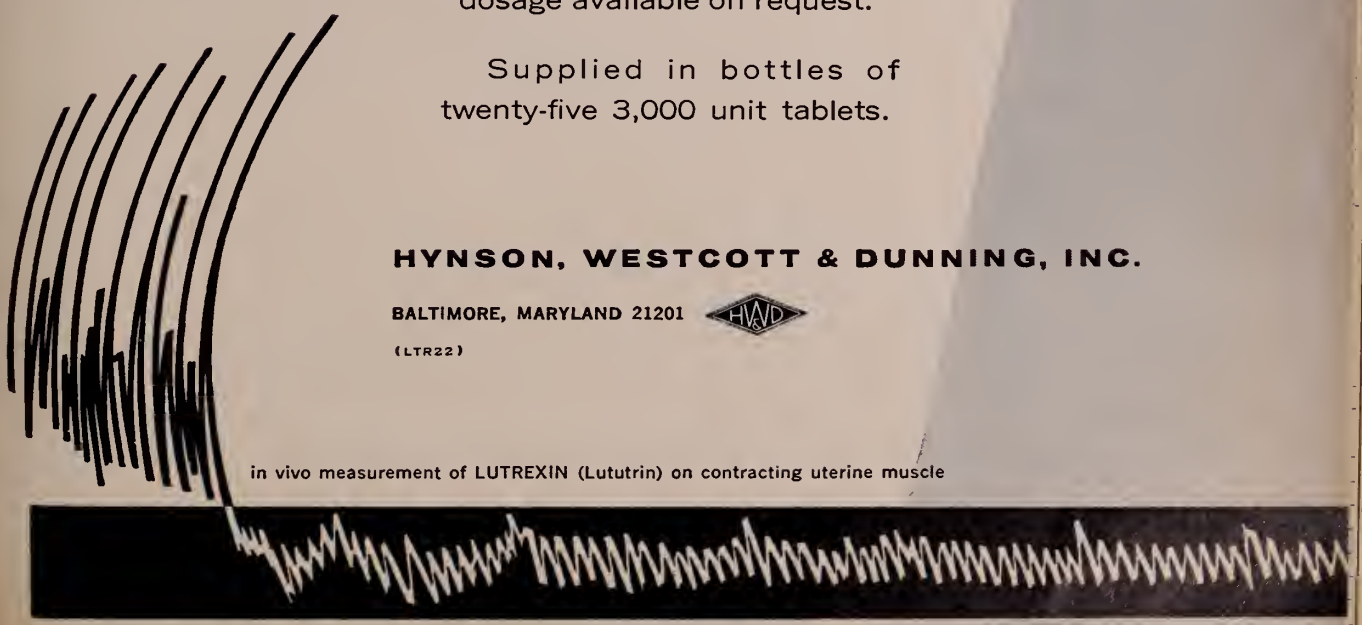
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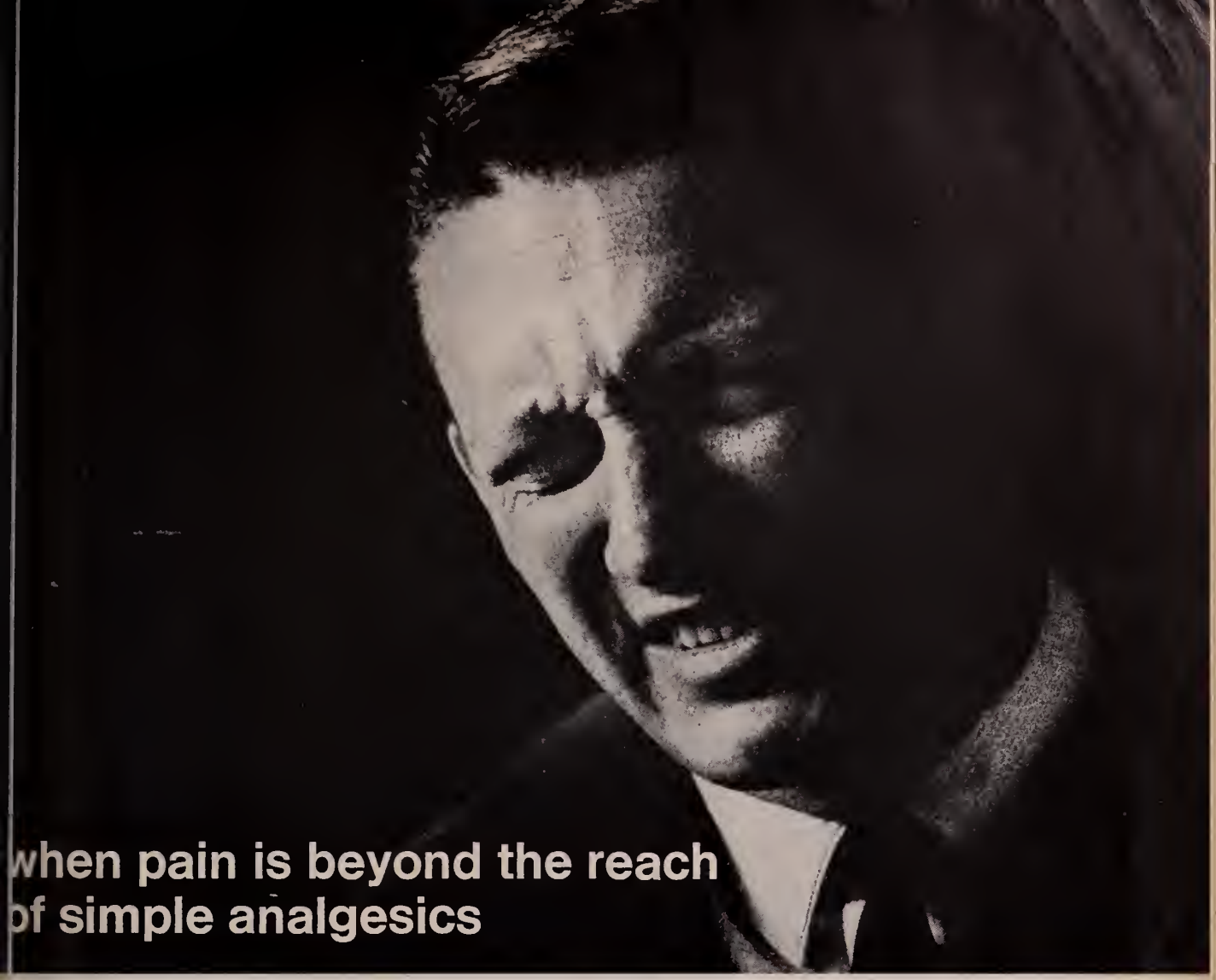
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1. Collective studies, Department of Medical Research, Winthrop Laboratories.

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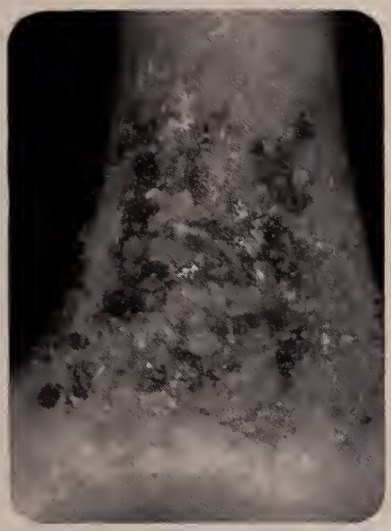
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The 1966-67 edition of the Membership Directory of The Medical Society of New Jersey will be sent to all members in good standing in mid September 1966. It will feature a biographical entry for each member, including name, address, telephone number, office hours, year of birth, medical school, year of graduation, New Jersey license number, type of practice, Board certification, fellowship(s), professional organizations, hospital staff appointments, and type of membership in MSNJ and AMA. . . in the order enumerated.

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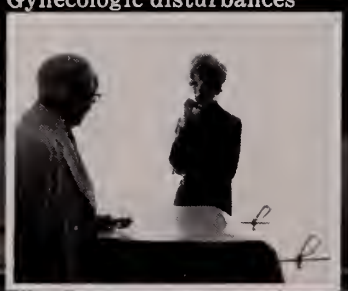
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1766 1966

CONTENTS • Pages 185 to 222

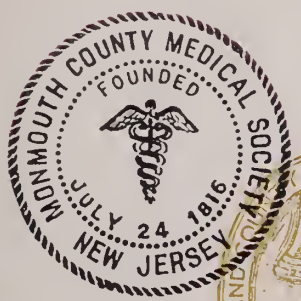
EDITORIALS
We Point With Pride 185
Listen to My Side of the Story 186
To Chicago in June 188
You Can't Weep in Outer Space 189

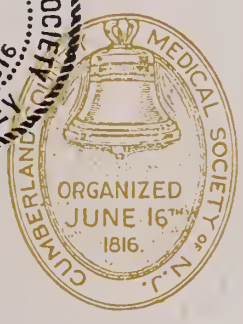
ORIGINAL ARTICLES
Obstructive Jaundice As A Complication of Duodenal Ulcer
Richard H. DuPree, M.D., Camden 190
Management of Laceration of Superior Vena Cava
Ronald J. Yadusky, M.D.; Nicholas J. Demos, M.D.; and Joseph J. Timmes, M.D., Jersey City 193
Animal Scabies in Human Hosts
Andrew Kallos, M.D., Kearny 197
Meckel's Diverticulum
Victor D'Ambrosio, M.D., Murray Hill 200
Diabetes Insipidus with Vasopressin Spray
Richard L. Fogel, M.D., East Orange 203
Treatment of Facial Fractures
Robby Meijer, M.D., East Orange 205
Multiple Bilateral Mammary Fibro-Adenomata in Identical Twins
John A. Ianacone, M.D., Paterson; and George T. Pack, M.D., New York, New York 207
Rehabilitation of the Disabled Worker
Monroe Berkowitz, Ph.D., New Brunswick 209

STATE ACTIVITIES
Announcements 192
Information for Contributors 196
Bicentennial Souvenirs 202
Chairmen of Councils and Committees 204
Trustee Minutes: April 17, 1966 212
State Legislation 214

OBITUARIES 215
BICENTENNALIA 216
BOOK REVIEWS 218
RESPIRATORY DISEASE ABSTRACTS 221

JUNE 1966 • Vol. 63, No. 6











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ON THE COVER

In its bicentennial year, the official seal of The Medical Society of New Jersey shares prominence with the official seals of those component societies celebrating their sesquicentennial anniversaries. According to the proceedings of the New Jersey Historical Society ("An Outline of the History of the Medical Society of New Jersey to 1900"), the first county medical societies organized in 1816 were: Somerset, May 21; Essex, June 4; Cumberland, June 6; Middlesex and Morris, June 11; and Monmouth, July 24.

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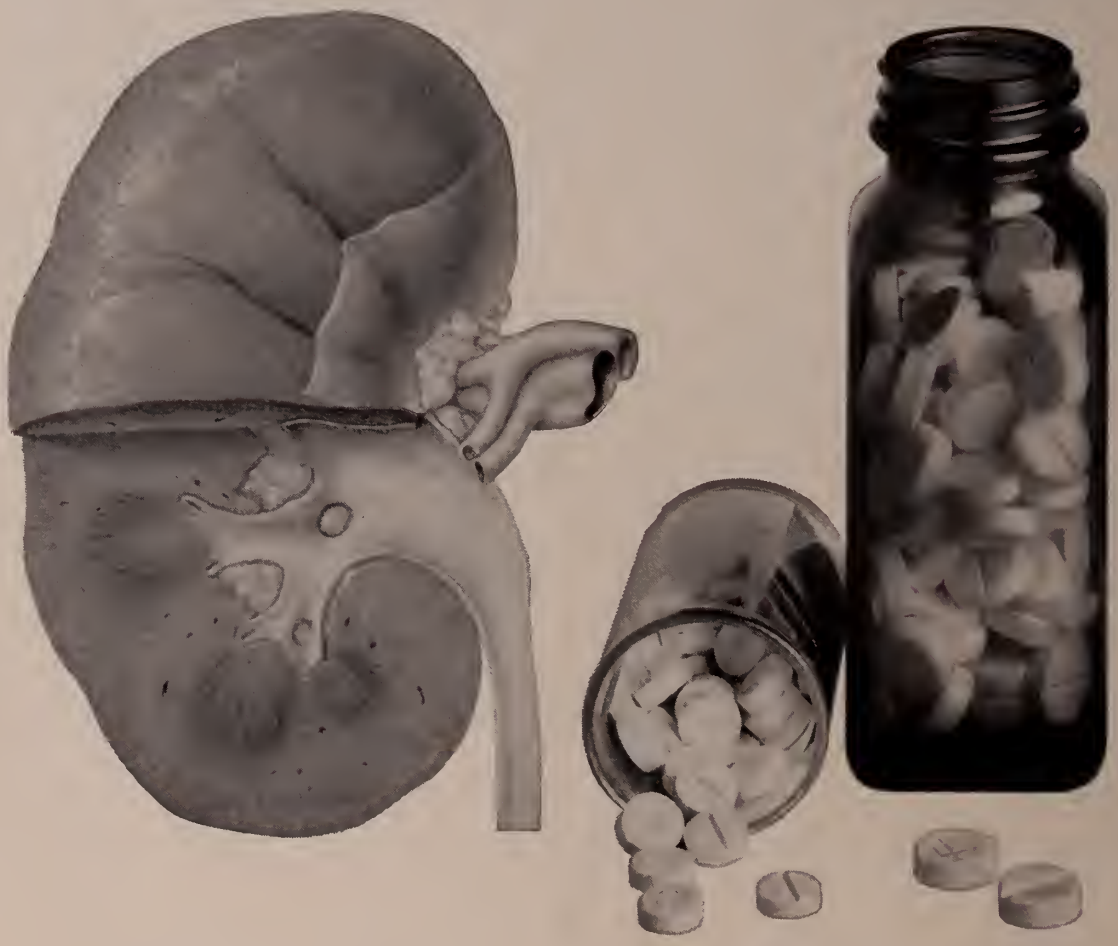
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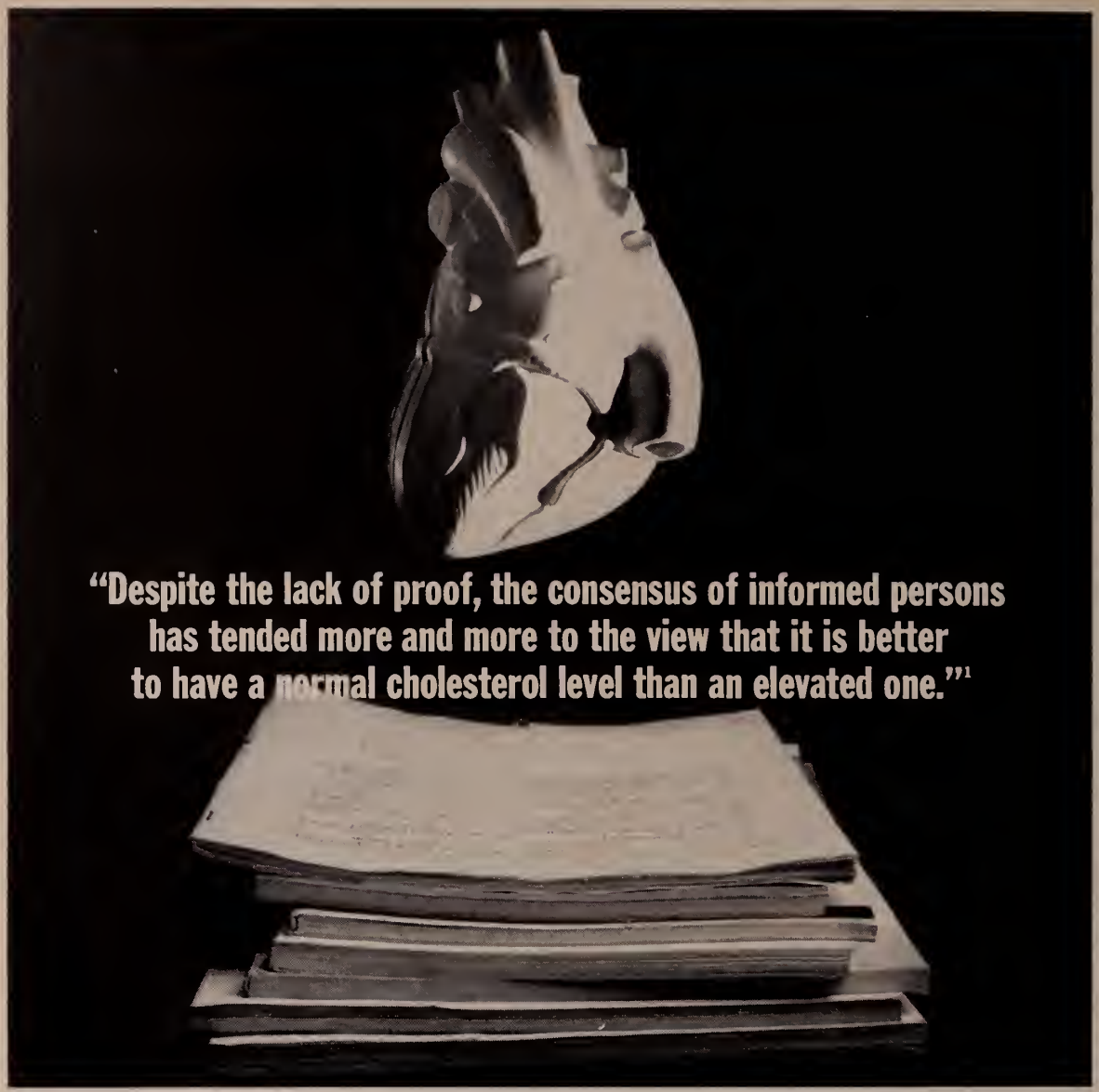
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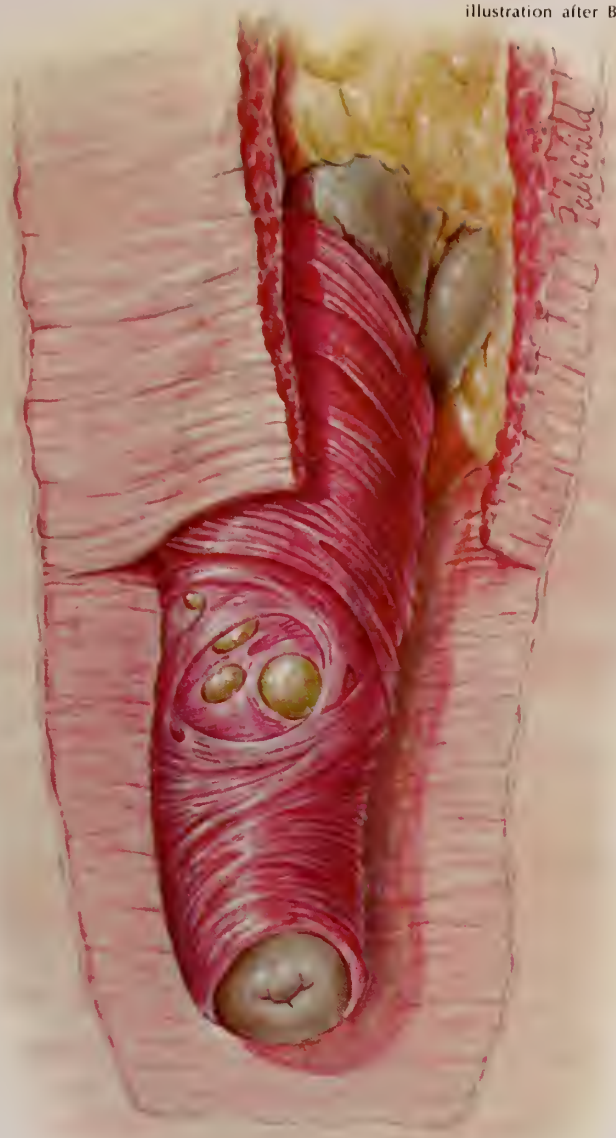
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The sphincter of Oddi is made up primarily of smooth muscle fibers. It permits the gall bladder to fill, regulates the flow of bile and pancreatic enzymes and in dysfunction is a primary cause of Biliary Dyskinesia. The sphincter of Oddi is but one of five major foci of smooth muscle spasm where SPACOLIN® (Alverine citrate) acts directly with rapid onset and long duration. No neurotropic side effects because Spacolin is a musculotropic counter-spasmodic unrelated to atropine or atropine-like drugs. Spacolin is not contraindicated in prostatic hypertrophy.

SPACOLIN® (Alverine citrate)

Each tablet contains: Alverine citrate . . . . . 120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations. DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort. PRECAUTION: Caution is recommended when using in hypotensive patients. SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

*Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

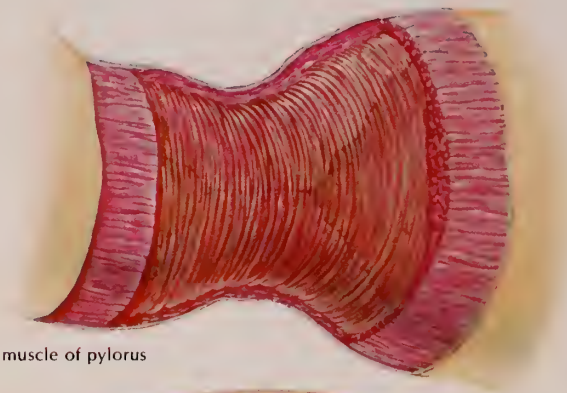
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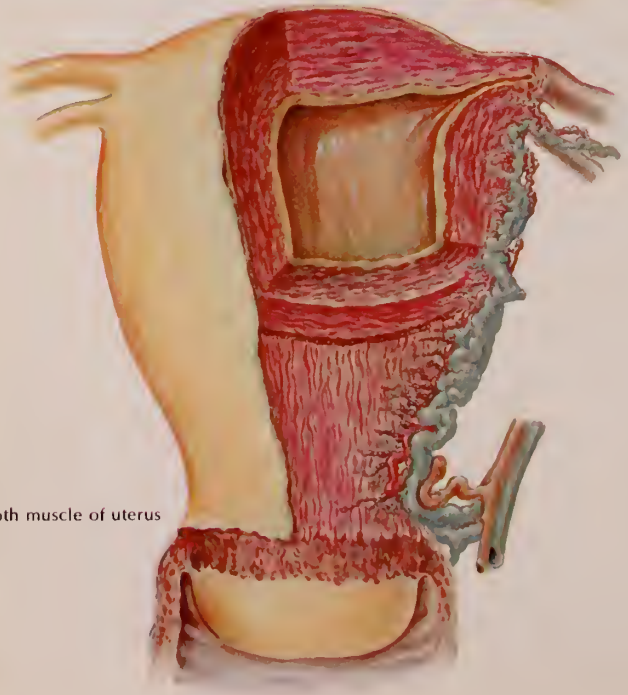
smooth muscle sphincter of Oddi



smooth muscle of colon



smooth muscle of pylorus



smooth muscle of uterus



smooth muscle of urinary bladder

to help restore and stabilize the intestinal flora

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TABLETS & GRANULES

for fever blisters and canker sores of herpetic origin

LACTINEX contains a standardized viable mixed culture of *Lactobacillus acidophilus* and *L. bulgaricus* with the naturally occurring metabolic products produced by these organisms.

LACTINEX was introduced to help restore the flora of the intestinal tract in infants and adults.[1,2,3,4]

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No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

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(LX03)

ferences: (1) Siver, R. H.: CMD, *21*:109, September 54. (2) Frykman, H. H.: Minn. Med., *38*:19-27, nuary 1955. (3) McGivney, J.: Tex. State Jour. Med., 16-18, January 1955. (4) Quehl, T. M.: Jour. of rida Acad. Gen. Prac., *15*:15-16, October 1965. (5) eekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

LX



Vell, Doctor, it's sort of
cross between a smoker's hack and a seal's bark.

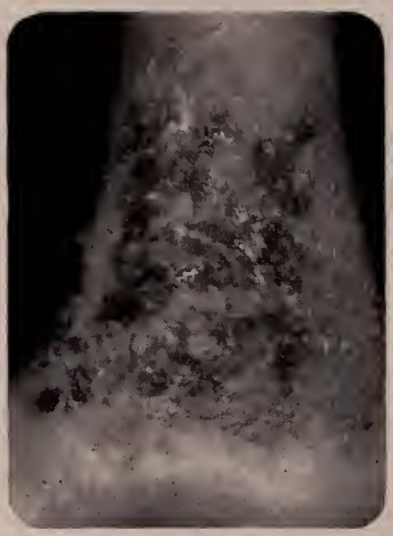
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the cough is the useless, exhausting type that often accompanies respiratory infection or llergy, you can provide prompt relief with Novahistine DH. Its decongestant-antitussive ction controls frequency and intensity of cough spasms without abolishing cough reflex. nd the fresh grape flavor of Novahistine DH appeals to children and adults alike.
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ach 5 ml. teaspoonful of Novahistine DH contains codeine phosphate, 10 mg. (Warning: ıay be habit forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, mg.; chloroform (approx.), 13.5 mg.; l-menthol, 1 mg. (Alcohol 5%). Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl ıuaiacolate, 100 mg.

NOVAHISTINE® DH
NOVAHISTINE® EXPECTORANT

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eczema: scourge of childhood



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Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attend with caution and observation, bearing in mind the potent spreading of infection and the advisability of discontinui therapy and/or initiating antibacterial measures. Generaliz dermatological conditions may require systemic corticost oid therapy. Steroid therapy, although responsible for rem sions of dermatoses, especially of allergic origin cannot be e pected to prevent recurrence. The use over extensive bo areas, with or without occlusive nonpermeable dressin may result in systemic absorption. Appropriate precautio should be taken. When occlusive nonpermeable dressin are used, miliaria, folliculitis and pyodermas will sometim develop. Localized atrophy and striae have been report with the use of steroids by the occlusive technique. Wh occlusive nonpermeable dressings are used, the physici should be aware of the hazards of suffocation and flamm bility. The safety of use on pregnant patients has not be firmly established. Thus, do not use in large amounts or f long periods of time on pregnant patients.

Packages: Tubes of 5 Gm. and 15 Gm.; ½ lb. jar.

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Duodenal mucosa with ulcer crater—Approx. 80× Magnification.

Loosening epithelial cells of nasal mucosa during early stage of cold—Approx. 1800× Magnification.

this issue: partners in misery

Partners in misery: common cold and duodenal ulcer*



A century or two ago our forefathers believed that the common cold was caused by an excess of evil humors. Today we regard these baleful humors as a result of the cold rather than its cause. Only in the last ten years have some of the offending viruses been cultivated, and we now know many others can be transmitted to human volunteers although they cannot yet be grown in the laboratory. Various body defenses react to infection by a virus, and in the respiratory tract the lung is protected by the phagocytic properties of the pulmonary alveolar macrophage.[1]

Because of the brief history and large proportion of unidentified viruses, effective prophylactic vaccines have not yet appeared. A universal antiviral agent seems even more remote. Meanwhile, these viruses continue to produce epidemics of upper respiratory infection at seasonal intervals, particularly in spring, fall and winter, during which they propagate and distribute progeny indiscriminately. As a result, they are responsible for significant work loss. Since the immunity afforded is temporary, recurrent infections are common.

This recurrent morbidity in spring and fall is shared by duodenal ulcer, itself a cause of significant loss in wages and medical expense. Thirty years ago Emery and Monroe reported 1,279 recurrences of peptic ulcer of which 13 per cent could be attributed to upper respiratory infection, thus confirming a long-held clinical impression.[2] While the inflammation, congestion and secretion of the mucosa of the nasopharynx in the common cold, and the hyperemia and hypersecretion of the gastric mucosa during acute exacerbation of a duodenal ulcer may not be directly linked, it is probable that the miseries of the infection are reflected in the pain of the ulcer. The following case history illustrates this point.

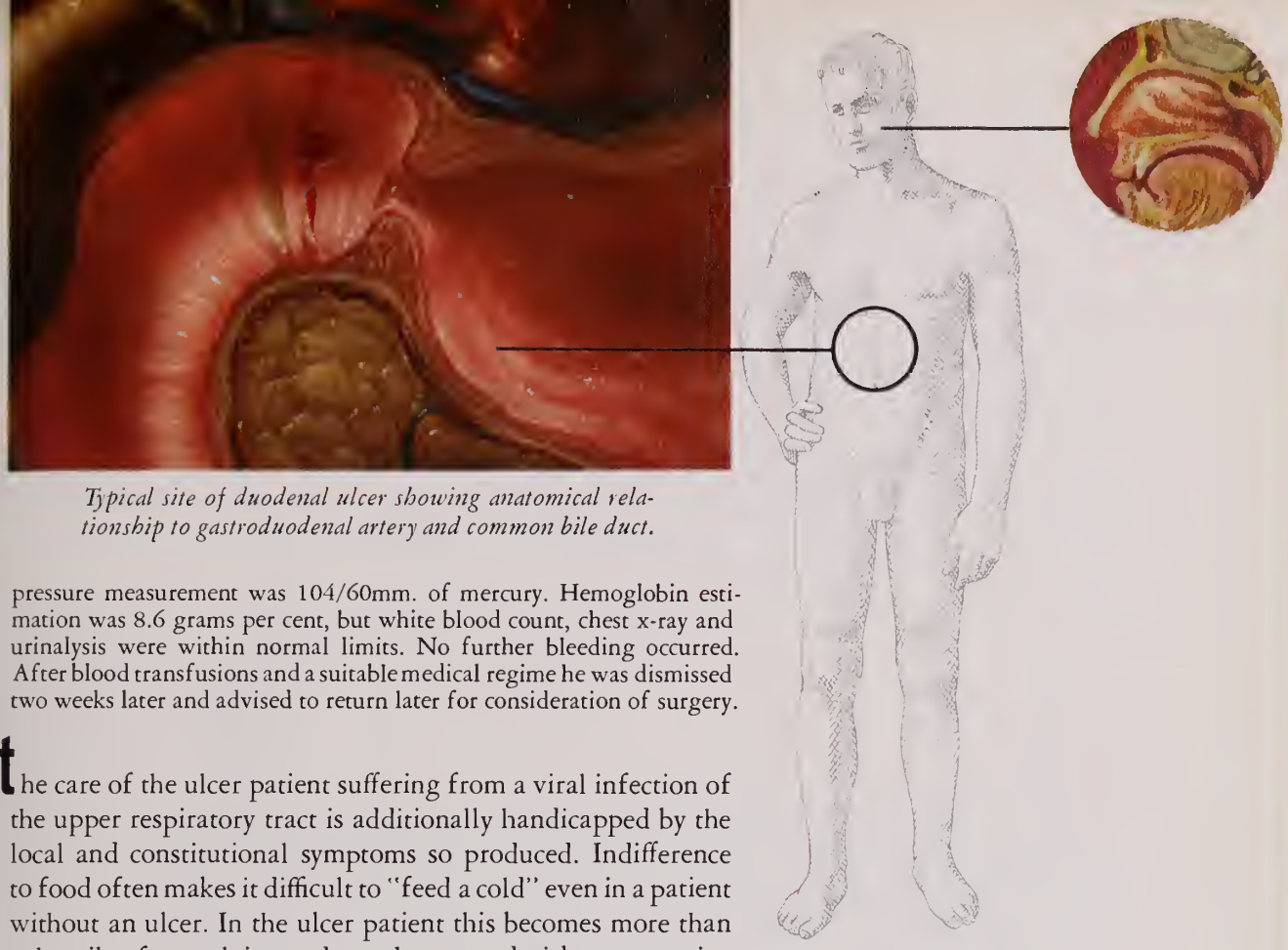
Case report A 48 year old white male executive, suffering from hematemesis and melena for 12 hours was admitted to hospital on April 8, 1965. He gave a history of duodenal ulcer proved by x-ray studies 23 years previously. In the intervening years he suffered from typical epigastric pain occurring two hours postprandially, usually for two or three weeks each spring and fall. A hospital admission two years earlier had followed hematemesis of moderate amount.

The present admission was preceded by a recurrence of pain during a period of unusual business pressure. In addition he caught a cold one week before his entry to hospital and his already irregular eating habits were made more so by loss of taste and appetite, blocked nose and general malaise. During the final 36 hours he used aspirin to relieve his cold, taking 2 or 3 tablets with a glass of water on 6 or 7 occasions. Before retiring he drank a glass of hot toddy.

He awakened about 1 a.m. and vomited dark red blood and recently ingested food mixed with whisky. Melena followed and he was transferred to hospital. On admission he was pale, cold and sweating. Apart from epigastric tenderness and black stool on the examining finger after rectal examination, his general physical examination was not remarkable. Temperature was normal, pulse was thin and thready with a rate of 114 beats per minute, and blood



The commonly found "clover-leaf" roentgenographic abnormality of chronic duodenal ulcer due to spastic contractions and scarring.



Typical site of duodenal ulcer showing anatomical relationship to gastroduodenal artery and common bile duct.

pressure measurement was 104/60mm. of mercury. Hemoglobin estimation was 8.6 grams per cent, but white blood count, chest x-ray and urinalysis were within normal limits. No further bleeding occurred. After blood transfusions and a suitable medical regime he was dismissed two weeks later and advised to return later for consideration of surgery.

The care of the ulcer patient suffering from a viral infection of the upper respiratory tract is additionally handicapped by the local and constitutional symptoms so produced. Indifference to food often makes it difficult to "feed a cold" even in a patient without an ulcer. In the ulcer patient this becomes more than a homily, for malaise and apathy towards irksome routine produce a lack of interest in adhering to an ulcer program and result in its eventual failure if these symptoms are not relieved. The absence of curative treatment for these viral infections has spawned many a strange therapeutic offspring and some of the more generally accepted remedies contain a special risk for the ulcer patient.

To the gastric physiologist, the shot heard around the world was not fired at Concord but was discharged through the stomach of Alexis St. Martin. The worthy voyageur had a more than modest thirst and on several occasions William Beaumont observed through the resulting fistula the changes of gastritis which followed an immoderate ingestion of alcohol.[3] It is now well known that alcohol stimulates the production of gastric juice and the patient with an ulcer, even in remission, should not drink alcohol without first taking food, milk or antacid. The use of various alcoholic remedies for the common cold is to be strongly discouraged in this type of patient. Factors already present can produce an acute exacerbation of ulcer symptoms without the added stimulus of alcohol.

Headache and facial pain, sore throat and generalized aching are subjective discomforts of viral infections of the upper respiratory tract or their complications. Relief from them is usually sought in the family medicine cabinet, and of all the medications habitually stored there, salicylates are the most frequently used. Oral ingestion of salicylates has produced



I can taste, Doctor!

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Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

One tablet on arising, in midafternoon and at bedtime assures round-the-clock relief. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

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substernal pyrosis and sometimes epigastric pain in susceptible individuals. Bleeding from erosions of the gastric mucosa has followed their use and has been severe enough in some instances to cause hematemesis and melena.[4] It has been suggested that interference with the protective mucous layer of the stomach allows this to happen. There is no evidence that hypersecretion occurs, but the taking of aspirin has been followed by exacerbation of ulcer symptoms and occasionally by gastrointestinal bleeding.[5] The ulcer patient with a cold should take salicylates with an antacid, or preferably other means of symptomatic relief should be found.

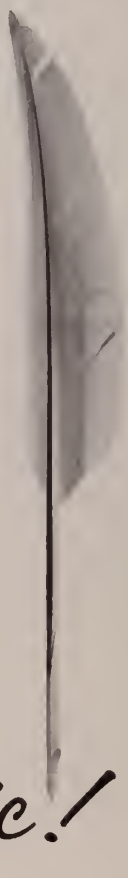
Caffeine has two actions on gastric secretion. One directly stimulates production of acid and the other potentiates the out-pouring of gastric juice as a response to other stimuli.[6] In high doses to animals, it has produced erosive gastritis and peptic ulceration. Caffeine-containing beverages are discouraged for the ulcer subject and forbidden during an acute exacerbation.[7] Many cold remedies contain caffeine.

To sufferers from allergic rhinitis springtime brings symptoms of nasal obstruction, loss of taste and smell and malaise similar to those caused by viral infection but due instead to allergens which at that time of year are principally tree pollens. Relief from these symptoms can be obtained, though not wisely, by the use of steroid medication. Unfortunately, chronic sufferers from these allergies have used this approach with varying degrees of success. Steroid hormones increase gastric secretion and delay the healing of experimental ulcers.[8,9] Clinically their administration has been associated with reactivation of healed duodenal ulcers, and with bleeding and perforation which were not always preceded by typical ulcer distress. Because of these harmful effects, their use in the ulcer patient is best avoided for other than serious medical problems and then only with adequate antacid coverage.

Summing up It is immaterial by which pathways the malaise and lassitude, depression and irritability activate an ulcer, but it is the physician's responsibility to ensure that the medications he selects to relieve the symptoms of a cold do not further aggravate the ulcer.

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Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

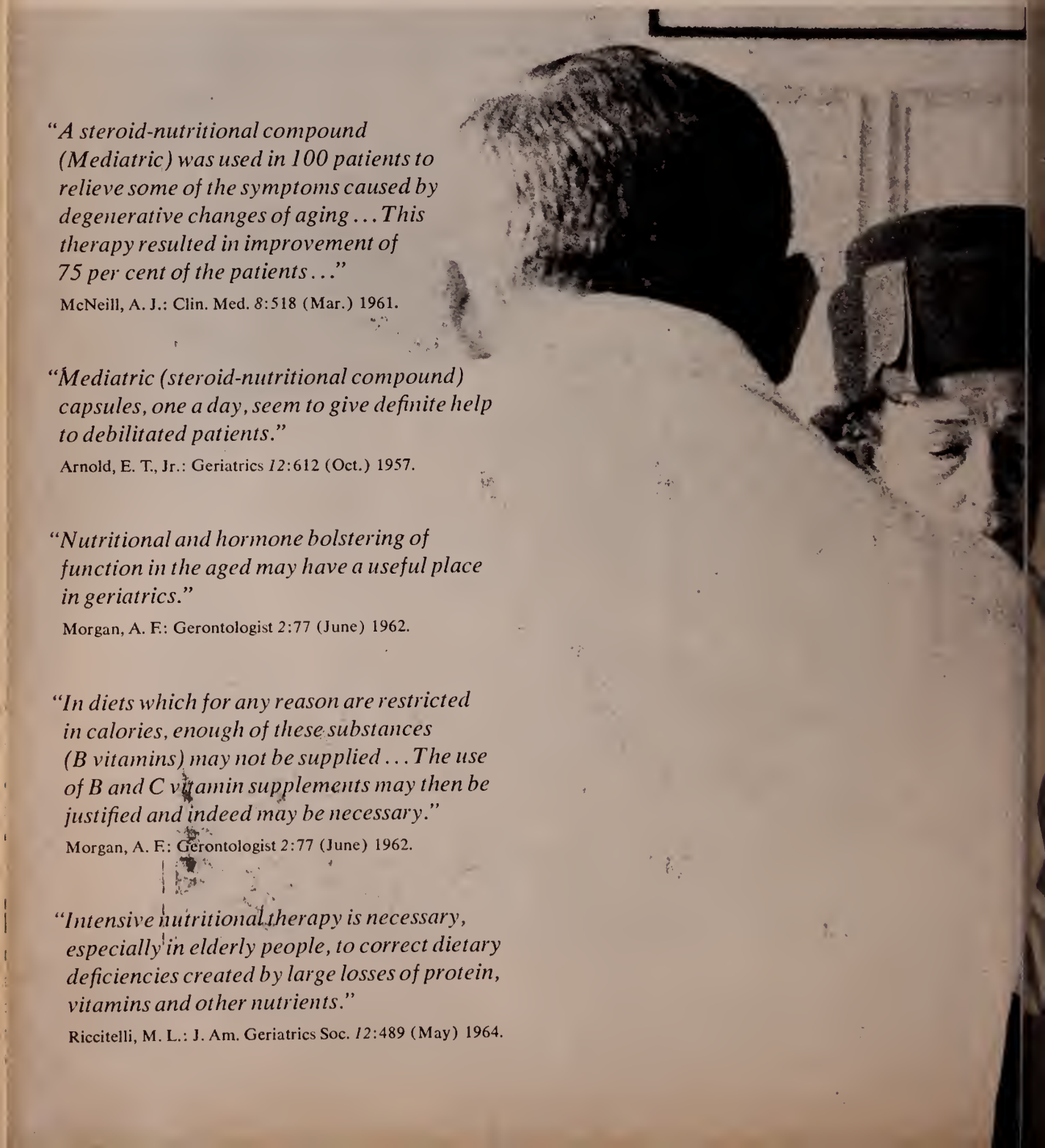
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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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EDITORIALS

We Point With Pride . . .

Except for two brief interruptions, this issue marks the 25th continuous year that Dr. Henry A. Davidson has served THE JOURNAL as its editor. Since its inception in September 1904, THE JOURNAL has had only five editors: one for as long as 25 years (Dr. Davidson) — and still going — and one so brief as 4 months. Thus we conclude that Henry Davidson not only holds the record of continuous service for our JOURNAL but is one of the senior editors among all state medical journals in America.

So that this outstanding achievement may not go unrecognized, this month THE JOURNAL is dedicated to Dr. Davidson, to pay public honor to him for his outstanding services — which have reflected credit to his profession and to MSNJ, and commendation to himself.

Dr. Henry A. Davidson was born in Newark, New Jersey in 1905, son of Dr. Louis L. Davidson, a prominent North Jersey practitioner. After receiving a B.A. degree from Columbia University in 1924, he entered the Jefferson Medical College, receiving his M.D. in 1928. Thereafter he devoted two years to the graduate study of neuropsychiatry, for which he received the M.S. degree from the University of Pennsylvania in 1931. After residences in both psychiatry and neurology, he returned to Newark to engage in the private practice of those specialties. From 1931 to 1942, Dr. Davidson served on the psychiatric and neurologic staffs of several hospitals, social agencies, and government departments in northern New Jersey and was on the psychiatric faculty of the Jefferson Medical College.

In January 1942, Dr. Davidson went on active duty with the Army of the United States. He served three years in the Southwest Pacific: for a year and a half he was registrar of an army hospital in Australia and for the next



year and a half was executive officer of a psychiatric hospital in New Guinea. In January 1945, the Surgeon General's office called Major Davidson back to the United States and assigned him to teach psychiatry and medical department administration at the School of Military Neuropsychiatry in Brentwood, New York. He remained on the faculty of this school from January 1945 to March 1946, when he was relieved of active duty and permitted to return to civilian life and to the editorial chair of our JOURNAL.

On being mustered out of the Army, Dr. Davidson accepted an appointment as chief of psychiatry for the Veterans Administration Regional Office in Newark; and after several years there, was promoted to chief of program development in psychiatry for the entire Veterans Administration, assigned to duty in the Central Office in Washington. This necessitated a brief interruption from active editorship of THE JOURNAL. In 1954 he accepted a post as clinical director of the Essex County Overbrook Hospital in Cedar Grove and resumed editorship of THE JOURNAL. In 1957 he became superintendent of that institution. He is a lecturer on hospital administration at Columbia University.

When the Seton Hall College of Medicine and Dentistry was established, he became the clinical professor of psychiatry, a title which he still holds in the (re-named) New Jersey College of Medicine and Dentistry.

Dr. Davidson has long been interested in and engaged in medical journalism. In 1931 he became an abstract writer for the *Archives of Neurology and Psychiatry* and later was appointed a copy writer on psychiatric and neurologic topics for the Davis Company *Cyclopedia of Medicine*. In 1934 he joined the staff of the *Year Book of Neurology, Psychiatry and Endocrinology* as a writer of digests and the following year began writing for *Medical Economics*. In 1937 he was appointed editor of the *Bulletin of the Essex County Medical Society* and in June 1941 became editor *of The Journal of The Medical Society of New Jersey*, his present position. Dr. Davidson's work as state society editor has gained recognition among the medical journalists of the country.

Dr. Davidson is the author of six books: (1) *A Short History of Chess;* (2) *A Handbook of Parliamentary Procedure;* (3) *The World of Doctor Whatsisname* (a collection of whimsical columns on hospital psychiatry which have appeared monthly in the *Journal of Mental Hospitals*); (4) *Opportunities In Psychiatry* (a vocational guidance manual); (5) *Forensic Psychiatry* (now in second edition); (6) *A Guide To Medical Writing*, which was based on his experiences as editor of this JOURNAL and is widely acclaimed as one of the few practical manuals on this subject.

He has also contributed to many other volumes, including the *American Textbook of Psychiatry*. He is parliamentarian of the American Psychiatric Association, and a past-president of the New Jersey Neuropsychiatric Association. Dr. Davidson is married to the former Adelaide F. Heyman. They have two children: daughter Ellen is a freshman student at Antioch College in Ohio, majoring in sociology; son Laurence is a sophomore at Harvard, majoring in the classics.

George B. Sharbaugh, M.D.
Chairman
Publication Committee

But Listen To My Side Of The Story

Now you are dedicating this issue to me. And at a gracious ceremony you handed me a plaque, accompanied by a pretty speech that made me feel like a pancake that has had syrup just poured over it. However, if you good people want to say all those nice things about me, who am I to disagree with so many of you?

I've been associated with this JOURNAL for 25 years, subtracting the four when I had that non-cancellable contract with Uncle Sam. But before that, I edited the Essex County *Bulletin* for four years, so I really do rack up a quarter of a century in medical journalism. I became editor of the state *Journal* in May 1941, which was the year of the Four Freedoms, the Atlantic Charter, and, of course, Pearl Harbor. The first President under whom I served was Watson Morris. The twenty-five men who were Presidents of our Society during my editorship were quite a galaxy! One was my old medical teacher at Jefferson, Henry Decker. It would take too long to list all 25, and it would seem odious to name only a few. But I can't let the occasion go by without saluting the memory of Royal Schaaf, who was pretty much the image of the ideal doctor. Naturally, I was personally closer to the other brethren from my own county — Ken Gardner, Jerry Kaufman, and Harrold Murray.

But the man who occupies the number 1 spot in my medical Valhalla was never President of The Medical Society of New Jersey at all. He was Henry Barkhorn. Only the most senior of my readers will ever know how much this Society, and particularly this JOURNAL, owed to Henry Barkhorn. More than anyone else, he shaped the course of the magazine. States with several medical schools tend to issue journals that become outlets for research at the schools. States that lack medical schools often develop journals that are made up essentially of papers read by distinguished visiting speakers at local meetings. In the April 1908 JOURNAL — (a fact dug up by the

indefatigable Theresa Goeke) — the editor defends himself against the charge that he was filling his pages with articles by out-of-state physicians. It was Henry Barkhorn who developed the policy of concentrating on work by New Jersey practitioners, but of accepting only material with a reasonable claim to scholarliness. One result of this policy was the stirring up of controversy. Early in my editorship, and against Dr. Barkhorn's advice, I adopted what I thought was a brilliant practice: I referred each manuscript to a specialist in the field. But just as the chairman had warned, this didn't work. Practically never did a paper by one local specialist satisfy another New Jersey specialist that it was a sound and scholarly piece of work. Eventually I had to fall back on the guideline which Dr. Barkhorn laid down when I was first appointed. He used to say: If *you* (meaning me) can understand it, then any non-specialist can understand it; and vice versa.

It would not be fitting for me to conclude this comment without a word about Dr. Barkhorn's even more important qualities: his human warmth, his radiant good cheer, his compassion, and his intellectual sensitivity. When he died, I wrote an obituary editorial with a heavy heart, and I said then — and repeat now: for such a man, the gates of Heaven were always open.

In the 1940s, The Medical Society of New Jersey had a three-room suite in an office building on Montgomery Street at State Street in Trenton. Although it was not on Broad Street, it was called the Broad Street Bank Building. Edith Madden, with a secretary, sat in the big reception room, and Roy Wilkes had one of the inner rooms. Miriam Nilis had the third room. Roy Wilkes was the first of our Trenton-based, full-time executives — his title was executive secretary. He belonged to what was then a new and small tribe — full-time executives for state medical societies. The tribe has grown mightily since.

I used to go to Trenton by train. I lived in Newark then, and in those days, trains were really trains. Besides, the Garden State Parkway and the New Jersey Turnpike were only pipe dreams in 1940. I would pick up a briefcase full of manuscripts and edit them on the train on my way to Newark. I sat in the smoker — this was long before the Surgeon General's Report — and wielded that blue pencil. I certainly dehydrated a lot of manuscripts on the Pennsylvania Railroad.

I suppose most of our readers have no memory of Roy Wilkes. This is a pity. He was a scholar and a gentleman, who devoted his full professional time to the interests of The Medical Society of New Jersey: the pioneer in a remarkably short list of New Jersey medical executives.

The two women in the office were, of course, indispensable. Miriam Nilis — who soon became Miriam Armstrong — was, at first, more useful to the JOURNAL than I was. She was a rapid, meticulous, and skillful worker, who soon was advanced from the nondescript title of editorial secretary to the more meaningful one of assistant editor. It is a tribute to our JOURNAL and to our Society that in this whole quarter-century span we have had only two assistant editors.

Anthropologists like to speak of some person or some elite group as carrying the culture of their society. And in The Medical Society of New Jersey, the thread that runs back these 25 years is surely Edith Madden. Edith is the one link between the little three-room suite on East State Street and the big mansion on West State Street. She was our Rock of Gibraltar in our rockiest days. Presidents and secretaries and executives might come and go, but Edith represented the continuity of our Medical Society tradition.

When Miriam Armstrong left, I was, at first, desolate because I had come to depend so much on her. I dreaded the long break-in period necessary for a new full-time assistant editor. But my fears were groundless. Miriam was a good teacher and Terrie was a brilliant pupil. Theresa Goeke—to give her her full name—breezed into the editorial office and

within a few months you got the feeling that she must have been born and brought up there. She brought ingenuity, imagination, initiative, and reliability with her. Certainly, as editor, I have been thrice-blessed, with the powerful backing of Henry Barkhorn, who rescued me from many embarrassing moments; and with the zealous and efficient help of two unusual assistant editors, I was able to enjoy every minute sitting in that editorial chair.

I have been lucky, too, in the chairmen of the Publication Committee under whom I served. After Henry Barkhorn's passing, the Trustees named Larry Evans as chairman of the Publication Committee and for a while the JOURNAL was in the curious position of having a psychiatrist as editor and a psychiatrist as Publication Committee chairman. However, we survived the surfeit of psychiatry. Then came Fred Rogers who has distinguished himself as a medical historian and who is now the Archivist of the Society. He was followed by Frank Rosen, who was an allergist to whom no one was allergic. And currently, George Bernard Sharbaugh, an ophthalmologist who sees all around our problems and who has had journalistic and editorial experience of his own. They all supported me and made my work easier, and I'm grateful.

In reviewing these notes, I see that I have got myself into a bind. I can't name all the wonderful people who helped, and, if I leave some out, that may be offensive. So maybe I should cut off the *dramatis personae* right now. I really can't, though, because there is one man who simply must be mentioned: the man who brought a truly professional quality to the work of being an executive director, the man who escorted us from a small and rather ingrown organization to one with contacts in the four corners of the country. I refer, of course, to Dick Nevin, our eloquent spokesman (who not only says all the right things, but says them in the right way), executive director, and coordinator extraordinary.

I owe a good deal to this JOURNAL. My *Guide to Medical Writing** is still being bought and read and referred to; and, of course, this was based on my experience with our state JOURNAL. My service here has brought me into contact with the leaders of medical journalism throughout the nation and with the leaders of organized medicine in New Jersey. And if I sometimes press down too hard with my blue pencil, please forgive it.

As for myself, I've enjoyed every minute of it, and I'm grateful to you all for giving me the opportunity. And when you add to that the honor of this plaque and dedication of this issue, it is perhaps too much!

At this point, believe it or not, words fail me!

Henry A. Davidson, M.D.

To Chicago In June

In medicine as in other spheres, the marketplace of things and the marketplace of ideas are incomparably larger in our time than ever before. The explosive growth of science and technology has placed before us a bewildering array of material goods and expanding knowledge. Every year the amount grows larger; the amount added in 10 years is astronomical, and sometimes appalling to the physician who left medical school a decade or more ago.

A two-fold problem is created for the physician by the bulging marketplace: (1) to stay informed of what is available, and (2) to be well enough informed qualitatively to appraise new goods and ideas, and to select those appropriate to his practice.

A physician can get by, of course, without making any real attempt to "keep up," either quantitatively or qualitatively. If he incorporates new drugs and new gadgetry into his practice occasionally — perhaps on the recommendation of a colleague or a manufacturer's representative — he will benefit by today's gen-

* Ronald Press, New York City 10010. — Advertisement

eral rise in medical goods and knowledge.

But American practitioners did not bring American medicine to its commanding position in the world with this kind of philosophy. On the contrary, our American medical system selects as its students the kind of people who don't want to settle for "getting by." Our psychiatric brethren tell us that the American physician tends to be an obsessive-compulsive personality, a person who makes great demands on himself and strives for perfection. And this devotion to excellence leads him to find the time to incorporate a remarkable amount of new information into his store of medical knowledge.

The information comes from: colleagues, medical journals, medical news publications, continuing education courses, medical meetings and conventions, drug service representatives, and some miscellaneous channels. The convention is a synthesis of all major methods. At the convention the physician has a chance to talk with representatives at commercial exhibits; he sees his colleagues and exchanges views; he attends lectures, exhibits, and seminars that together constitute a course in up-to-the-minute medical thinking.

Of all medical conventions, none compares with the annual convention of the American Medical Association as a showcase for medical goods and knowledge. Surely no other medical convention matches the range of subjects presented, from reviews of general medicine to experimental medicine and therapeutics.

The 115th Annual Convention of the AMA will be held in Chicago June 26 to 30 this year.

Among special presentations planned is a general session on population expansion, a crisis unique to the mid-twentieth century.

The annual convention offers almost unlimited opportunities for absorbing new information and gaining new perspectives.

Time spent in Chicago this June will be time well spent.

You Can't Weep In Outer Space

Maybe our generation won't be much involved in a weightless existence; but our children, and certainly our children's children, will be able to survive—or perhaps the word is "enjoy"—long periods of weightlessness in outer space. And it is interesting to speculate about the effects of zero gravity on physical diagnosis and treatment. The obvious difficulty will come in drinking fluid medication or swallowing pills when gravity is not there to keep the medication moving in the right direction. One wonders about the administration of an enema under these conditions.

At the Astronautical Congress in Athens last fall, Dr. Constantine Generales underscored (if that is the right verb) some of the problems. The behavior of circulatory system emboli, for instance, would be modified. Indeed the entire fluid-gas-exchange system would be affected. If fluid got into the pleural cavity, it would be uniformly distributed producing an odd x-ray picture. You'd have trouble diagnosing intestinal obstruction because you so often depend on fluid levels in the x-ray picture. When doing a roentgen study of the stomach, you'd have to be careful not to be confused by the central location of the air bubble which (in the old days of gravity) used to be on top of the gastric contents.

The diagnostic value of edema of the ankles would be lost because extracellular fluid, instead of rolling down to the "bottom" of the body, would be evenly distributed. And you couldn't use any barometers, balance scales, fluid sphygmomanometers, and instruments with pendulums.

On the other hand, there should be less back pain, kyphosis, ostearthritis, and disorders due to faulty posture or unhygienic walking habits. And, they tell us, there are no tears in space. Or, at least, the lachrymal fluid is just as likely to flow over the eyeballs (producing, maybe, a conjunctivitis?) as to flow down the cheeks. Come to think of it, that might make a good theme song: "No Tears in Space."

ORIGINAL ARTICLES

Obstructive jaundice is a rare complication of duodenal ulcer. Or is it really so rare?

Obstructive Jaundice As A Complication Of Duodenal Ulcer

Richard H. DuPree, M.D./Camden

In a summary of 2,650 reported cases of duodenal ulcer from an accumulated series, Engle and Spann[1] were able to find only one in which minimal jaundice was reported. The experience of most observers[2] in gastroenterology seems to fix the ratio at a much higher figure than this. Jaundice when discernible is rarely severe[3] and the serum bilirubin then seldom exceeds four or five milligrams per cent.[7] Indeed, in all the world's literature, fewer than 100 cases[1,3,9] have been reported in which obstructive jaundice is coexistent with or caused by peptic ulcer. The largest known series (Snape[4]) includes only six individual cases collected over three years. This suggests that the condition is commoner than the literature indicates.

Yanovsky[14] reported 557 cases of gall bladder afflictions, with 130 cases of duodenal ulcers and 143 gastric ulcers. This included 19 cases of combined ulcero-biliary disease, of which 15 were combined choledocho-duodenal lesions, five with jaundice—and all with hypersecretion. The causative factors were not documented, but Yanovsky felt most cases were due to the common factors of vagotonia and focal infection with a rare occurrence of the gall bladder involvement causing the ulcer or *vice versa*.

Scott[10] outlined the causes of obstructive jaundice of the extra-hepatic variety as follows:

1. Stone in the common duct — most frequent.
2. Neoplasia with pancreatic and ampullary malignancy as the next most common offenders.
3. Inflammation, of which one of the least common causes is ulcer disease.

Walker and Large[11] believed that ulcer disease was the underlying cause in most cases and that jaundice was usually present.

In view of the rarity of the condition, the difficulty in diagnosis, and the necessity of the consideration of this condition in the differential diagnosis of obstructive jaundice, the following case report is submitted.

A 69-year-old diabetic was admitted to Our Lady of Lourdes Hospital, Camden, New Jersey, with the report that she first noted jaundice associated with nausea, abdominal distention, and discomfort (lasting four days) some five months prior to admission. A week later, she developed some abdominal distention associated with mild nausea. Her physician prescribed tolbutamide for the diabetes, which had been previously well-controlled on diet alone. After one week, she complained of icterus, light foul-smelling stools, dark urine, fatigue, pruritis, anorexia, and mild cramps in the right upper quadrant. The only other medications were trifluoperazine and Parnate,® given continuously over the last five to six months, without problems. Her past medical history was essentially non-contributory other than an attack of diphtheria with a partial paraplegia and recovery during her childhood.

There was mild exertional dyspnea and palpitation. She was reported to have a heart murmur which had been present for several years. She was postmenopausal for about 20 years.

She was a well-developed, well-nourished woman in no distress. There was no evident weight loss but she was markedly jaundiced. There were occasional ventricular extra systoles and a grade 2 systolic murmur, ejection in type, which was best heard at the apex and transmitted to the base with slight cardiac enlargement. A small diastasis recti was present. Her liver was palpated on deep inspiration about two centimeters below the right costal border, with a tender, round firm edge. The stool was clay colored. No palpatory abnormalities

of her pelvic organs were found. The remainder of the physical examination was negative, other than traumatic excoriations of her skin. Blood sugar was 128. There was a "trace" of sugar in the urine.

The laboratory studies were:

Blood Sugar	128 mgm %
BUN	20 mgms %
Serum Transaminase	38 units
Alkaline Phosphatase	7.0 Bessie Lowry Units
Cholesterol	250 mgms %
Total Serum Protein	7.6 grams %
A/G Ratio	Normal

Complete blood count normal.

Urinalysis

Sugar	Trace
Bile	Positive
Urobilinogen	Negative

The rest of the studies were normal.

Serum Amylase	177 units
Serum Lipase	0.8 units
Serology	Negative
Total Bilirubin	16.5 mgm %
Direct	12.3 mgms %
Indirect	4.2 mgms %

Prothrombin Times were maintained at 100% during her entire hospital stay.

She became progressively more jaundiced during her three weeks of preoperative evaluation. There was no evidence of a remission of the obstruction. The stools remained light and the urine very dark. The electrocardiogram demonstrated frequent ventricular extra systoles, a first-degree heart block, ST segment, and T wave changes. X-ray of the abdomen showed vascular calcification of both iliac vessels. Chest x-ray was normal. Gastro-intestinal series showed an irritable duodenal bulb with an ulcer in the central portion and a pressure defect on the distal third of the greater curvature of the stomach, which suggested a local mass lesion. Four days later, a second x-ray series demonstrated a deformed duodenal bulb with an active ulcer, without enlargement, displacement or mucosal change in the loop. The pyloric end of the stomach was normal and free of any evidence of intrinsic pressure defect on this study.

This was obviously unremitting obstructive jaundice. Exploratory surgery of her biliary tract was done three weeks after admission. The fundal portion of the gall bladder was thickened and was firmly attached to the duodenum. The surgeon felt that a cholecysto-duodenal fistula might exist, but in the dissection of the two organs, no communication was found. There were, however, dense fibrous adhesions between the two structures. A cholangiogram showed the common bile duct to be well aligned and of normal caliber. There were no filling defects nor were there obvious calculi in the common duct or ampulla. The liver was somewhat nodular and green. Subtotal gastrectomy and cholecystectomy were done. Her clinical condition precluded a liver biopsy at this time. The postoperative course was uneventful. She discharged on the 19th post-operative day with no untoward sequelae to this writing.

In this case, we find marked obstructive jaundice, unremitting in type, without preceding ulcer distress or evident gall bladder signs or symptoms, in an age group where the diagnosis of carcinoma of the pancreas is most likely. The ulcer in the duodenum, the lack of distortion of the duodenal loop, the hepatic enlargement, and a non-palpable gall bladder all tend to support the diagnosis of a benign obstruction, such as cholecystitis or intrahepatic cholestasis due to drug sensitivity. There were no evident signs of hepato-cellular disease from a clinical or laboratory standpoint.

The operating surgeon and pathologist felt that the ulcer was the precipitating cause of the cholecystitis, choledochal inflammation, and the biliary cirrhosis with the probable sequence of events being: ulcer, cholecystitis, cholangitis, and biliary cirrhosis. Interestingly, the most common occurring mechanism in the collected group of 36 cases (see references 1, 4, 5, 6, 7, 8, and 14) seems to be either pancreatic penetration, periduodenitis, or both. A few reports were of abscesses involving the hepato-duodenal ligament and two described walled-off perforated ulcers with abscesses. It is conceivable that this could have been primarily a cholecystitis with subsequent ulceration, which can neither be proved nor disproved. A diabetic elderly woman is not a typical ulcer candidate. I have been unable to document this particular sequence.

The mechanisms of possible patho-physiology of jaundice with ulcer disease as modified from DaGradi *et al*[13] can be outlined as follows:

1. The occurrence of two separate conditions.[14]

2. Cholecystitis and choledochitis initiating the ulcer.[11]

3. Ulcer disease as the causative factor by:

(A) Bleeding and absorption of the by-products, particularly if the duodenum were partially obstructed below, as reported in the unusual case of Bradham[8] which had dissected submucosally, hemorrhaged, abscessed, and intussuscepted with periportal and peridochal edema.

(B) Obstruction of the common duct by:

(1) Perforation into the duct.

(2) Periduodenitis; perivaterine and/or pericholedochal inflammation and subsequent fibrosis.

(3) Pancreatitis with or without abscess formation.

Note that three-fourths of all people have the common duct buried in the pancreas behind the apex of the

duodenal bulb[4]; and of 70 consecutive perforated ulcers, 50 had evident pancreatitis.[2]

(4) Involvement of the hepatoduodenal ligament.

(5) Involvement of the gall bladder *per se* with subsequent cholecystitis, choledochitis, and cholangitis as suggested in this case.

With fewer than 100 cases collected to date and by a few series of more than three cases[4,6,14] assembled in a relatively short period, this complication may be more frequent than reported and warrants closer observation on the part of all investigators with attention towards the mechanisms of development of obstructive jaundice by an ulcer as outlined.

Summary

A case of duodenal ulcer causing obstructive jaundice is reported and a review of some of the mechanisms involved in the causative association is discussed.

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414 Cooper Street

Diabetes Symposium

On Thursday, June 16, there will be a colloquium on the diagnosis and treatment of diabetes. The meeting will be at the Somerset Hospital in Somerville, promptly at 4:30 p.m. Dr. Robert Areson of Montclair will be moderator; and essayists will be S. S. Bergen, Jr. and Gerald J. Friedman, both well-known New York metabolists. This session is under the joint auspices of the State Health Department and the New Jersey Academy of Medicine.

Conference on Infant Mortality

On August 12-13, San Francisco's Fairmont Hotel will be the scene of an unique seminar on Infant Mortality sponsored by the AMA. For details, write to the Committee on Maternal and Child Care, AMA, 535 North Dearborn Street, Chicago, Illinois 60610.

New Booklet on Peptic Ulcer

For 15¢ your ulcer patient may obtain USPHS Publication Number 280 (Series 71) entitled *Peptic Ulcer*. This 13-page paperback gives direct, sound, and legible information to ulcer sufferers and their families. Tell your patient to write to Government Printing Office, Washington, D.C., 20402.

Functional Bowel Disorders

Save Monday evening, June 27, for a symposium on gastroenterology at the Paul Kimball Hospital in Lakewood. The panel includes Dr. Leo H. Siegel, Dr. Abraham Friedman, and Dr. Bernard H. Chaiken — all well-known New Jersey gastro-enterologists. The program, which starts at 8:30 p.m., is under the aegis of the New Jersey Academy of Medicine.

Penetrating posterior lacerations of superior vena cava are rare; and recoveries from this injury are rarer still. Here a group from the Pollak Hospital describes a useful management technic.

Successful Management of Laceration of Superior Vena Cava*

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/ **Jersey City**

Isolated laceration of the superior vena cava from a penetrating wound of the chest has been infrequently reported in the medical literature. Posterior wound of entrance has not been common in those reported cases. There is a difference in the treatment for superior vena caval laceration compared to the usual routines for penetrating chest wounds not involving the superior vena cava. This paper presents a case with survival of a penetrating chest wound with the wound of entrance posteriorly, involving an isolated laceration of the superior vena cava extrapericardially; we also wish to emphasize the treatment technics helpful in superior vena caval laceration.

A 20-year-old man was brought to the emergency room at midnight. His blood pressure was unobtainable. The pulse was fast and thready. A bullet was palpable subcutaneously at the suprasternal notch. Surrounding the bullet, there was some fluid collection with crepitus due to subcutaneous emphysema. The bullet wound of entry was between the right scapula and the spinous processes. Dullness to percussion and absence of breath sounds were present over most of the right chest. An anterior-posterior chest x-ray revealed a large fluid accumulation in the right lower chest and a bullet at the level of the third vertebra. He also had a fracture of the right fifth rib. A right thoracotomy was done two hours after admission.† During the first hour of anesthesia, his systolic blood pressure was 60, but at times it was unobtainable even though he was receiving blood transfusions in the veins of three extremities. On opening the right pleural cavity, a few liters of blood were quickly evacuated. A longitudinal three centimeter laceration of the superior vena cava was then seen. The laceration was repaired with a continuous vascular suture. Inspection revealed that the bullet had traversed the apex of the right upper lobe. After suture of the vein laceration and after fifteen units of blood, the systolic blood pressure became 84. This reached normal levels two hours after the initiation of anesthesia. The bullet was removed through a small overlying skin incision.

The chest incision was closed in layers and the pleural cavity was drained with two tubes. The right lung reexpanded well. On the 18th postoperative day, he developed a stiff neck with an area of cellulitis over and to the right of the suprasternal notch. A small incision was made under general anesthesia and this area responded to drainage and antibiotics.

One month after injury, the patient was discharged. He was completely well with no evidence of superior vena caval obstruction. The chest x-ray showed complete expansion of the right lung. There was no x-ray evidence of fluid accumulation.

Isolated laceration of the superior vena cava from a posterior penetrating wound of the chest has been infrequently reported:

Burnett and Baillie[5] in 1962 found only four cases where the patient had survived. The entrance wound was on the anterior chest wall in all four cases. Quest *et al*[18] in 1965 reported 61 patients with vena caval injuries who were alive on admission. Four of these had superior vena caval injury, but they also had associated injuries to other major vascular structures. Cordice[6] with 507 cases of chest trauma found only two with superior vena caval stab

* This work is from the B. S. Pollak Hospital for Chest Diseases. It was supported by N.I.H. Grant HE 5631-02. Dr. Yadusky is chief resident in thoracic and cardiovascular surgery, Dr. Demos is a postdoctoral trainee in heart surgery, and Dr. Timmes is Director of the Cardio-Thoracic Surgery at the hospital as well as Professor of Surgery at the New Jersey College of Medicine and Dentistry.

† Case records through the courtesy of Dr. Irving Marshall, Surgical Service, Jersey City Medical Center.

wounds. Burnett and Baillie[5] reported on 232 patients treated for injuries related to the thorax. Only one of these patients had had injury to the superior vena cava. Beall[4] reported three superior vena caval injuries in 64 cases of large vein trauma.

Two explanations are possible. Either isolated laceration of the superior vena cava from a penetrating wound of the chest does not often occur in chest trauma, or these patients do not survive to reach the hospital. Ochsner *et al*[17] in 1961 reported 27 patients with laceration of the superior vena cava. Only two survived to reach the hospital. Quest *et al*[18] note that all vena caval injuries are serious, as over one-half of the patients with such wounds are dead on arrival at the hospital and another fifty percent will die in spite of therapy, mostly because of exsanguination and shock.

Pneumothorax (with or without tension) might result in air embolism and death when there is an associated laceration of the superior vena cava. Air embolism can occur at any time, since there is a source of air and an uncollapsed vein containing low or negative pressure.[7] The largest group of patients with penetrating injuries to the chest have both air and blood in the pleural cavity.[9]

Anatomically, superior vena caval lacerations do not occur often in chest trauma cases. This is because penetrating injuries to the chest are generally caused by a right-handed assailant with a knife or gun[6,9,8] and the wounds of entrance tend to be anterior. Gray *et al*[9] in 1960 cited 769 patients with penetrating injuries to the chest and 439 injuries were to the left side of the thorax. Garzon *et al*[8] in 1964 reported on 301 consecutive patients with penetrating thoracic wounds admitted alive to the hospital. The sites of penetration were *anterior* to the mid-axillary line in 70 percent of cases. Sixty-five percent of the anterior wounds were to the left of the mid-sternal line. The posterior wounds occurred equally to the left or right of the spinal column.

Other causes of superior vena caval injury, such as perforation or rupture, are rare. Abbott and Leigh[1] said that they had never found a report to date (1964) of such a lesion. Another potential source of injury (reported in 1962 by Barry[3]) is a polyethylene catheter lying free in the superior vena cava. He found that one case had been reported of a fragment of catheter that acted as an embolus. Kulinick *et al*[11] in 1963 reported a wound of the right auricle and superior vena cava. It is reasonable to expect, however, that injuries of the superior vena cava in association with wounds of the heart should have a higher mortality rate and, thus, these patients may not survive to reach the hospital. Garzon *et al*[8] in 1960 said that, up to then, no patient with a gunshot wound of the heart had survived long enough to be included in his study of 301 patients with penetrating thoracic wounds. Rather than rupture or laceration, thrombosis of the superior vena cava occurs with such injuries as blunt trauma,[16] traumatic phlebitis,[21] traumatic mediastinitis,[20] bullet-wound purulent mediastinitis,[16] certain post-operative states,[2] and old intrapleural hematoma with eventual superior vena caval obstruction.[13]

It seems reasonable to conclude[10] that an isolated laceration of the superior vena cava from a penetrating wound of the chest is infrequent and is associated with a high mortality.

Treatment of Superior Vena Caval Injury

The mortality of superior vena cava laceration may be due, in part, to the need for treatment methods differing from the usual technics of other types of penetrating chest wounds. Furthermore, injury of the superior vena cava may not be an isolated wound. It is likely to be associated with intra-pericardiac injury, wounds of the heart[11] or other major vessels,[18] or damage to the lung and phrenic nerve.[5]

It is futile to try to correct hypotension by transfusion alone in the presence of cardiac tamponade, tension pneumothorax, massive pneumothorax, or a sucking (traumatopneic) wound. These conditions all produce a phy-

siologic hypotension which is unrelated to a decrease in effective blood volume.[5] Uncrossmatched O Rh negative whole blood may be given freely when indicated for rapid continuing hemorrhage. Under those circumstances, surgery does not await restoration of normal blood volume; it can be part of the treatment to restore a normal blood volume by controlling further hemorrhage.[18] In superior vena caval laceration, if blood replacement can match blood loss, an underwater chest tube or thoracentesis should not be used unless this is needed for acute distress or to counteract the risk of air embolism with pneumothorax. Partial or complete arrest of hemorrhage from the superior vena caval laceration may have occurred from pleural tamponade.[5] There is good basis in cases of pericardial tamponade for controlled pericardiocentesis; and, so too, in these cases of

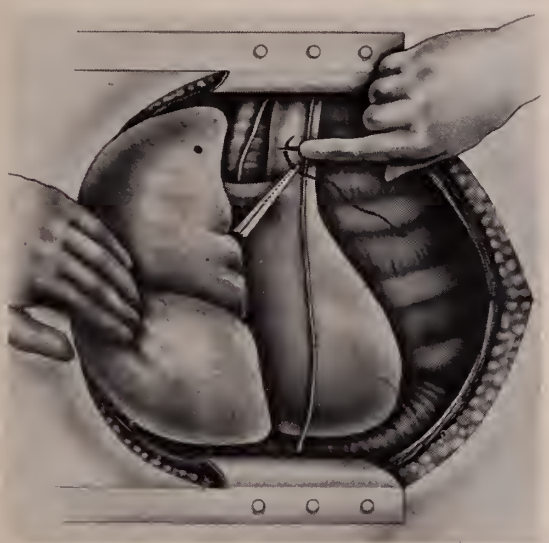


Figure 1. Note the laceration in the superior vena cava and a round defect the bullet has created in the right upper lobe.

pleural tamponade, a good argument for *controlled* thoracentesis may be made.[5] The large amount of blood in the pleural space may well help to control further hemorrhage until the thorax is opened surgically causing a subsequent fall in intra-thoracic pressure. Thus, one can see that there should be a difference in the treatment routines for penetrating chest wounds *with* superior vena caval laceration, compared to the early care of penetrating chest trauma *without* superior vena caval laceration. The latter has as its general objective the early and, if necessary, repeated or continuous aspiration of fluid and air from the pleural cavity[9] to achieve complete expansion of the lung in the shortest possible time[19] after an airway has been established and blood loss treated.

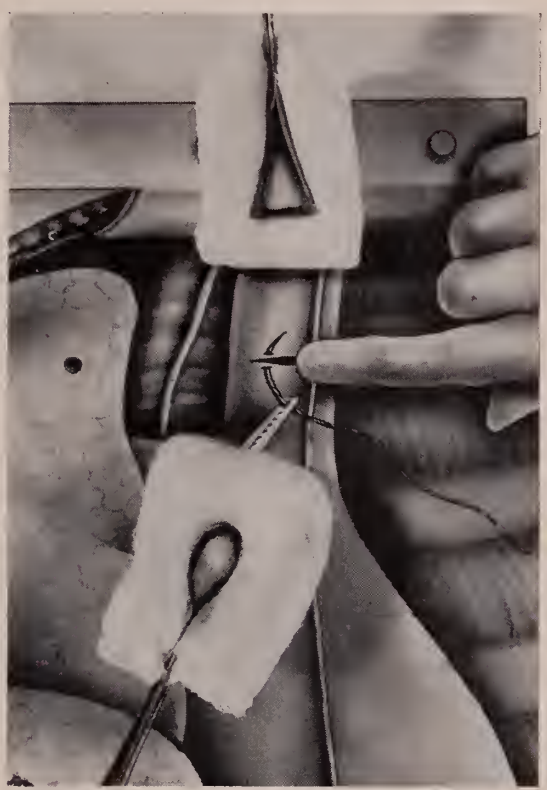


Figure 2. Note the sponge sticks which are used to control bleeding through the laceration during suture.

All four extremities might need to be used during thoracotomy for repair of a superior vena caval laceration on entering the pleural space.[5] Pre-operatively, therefore, a large amount of blood should be made ready. Finger tamponade of the laceration, if the hole is small enough, may be the best and fastest way temporarily to control bleeding after the chest is opened, particularly if pleural tamponade could stop the bleeding with the chest closed. Pressure by sponge sticks above and below the site of laceration in the vena cava may temporarily control bleeding as was done in this case to allow suturing in a dry field. A leg vein for blood replacement generally is pre-

ferable for superior vena caval injury and an arm vein for inferior vena caval injury. Autotransfusion of intra-pleural blood may be needed in some cases.

Repair by direct suture is preferred.[18] If there is difficulty in mobilizing the vena cava for repair of through and through vena caval injuries, this may be managed by enlarging the anterior wound to repair the posterior wound from within the vena cava, and finally closing the anterior wound as a venotomy.[18]

An abdominal retroperitoneal hematoma seen at laparotomy should generally be explored to repair the laceration of the inferior vena cava.[18] This principle of exploration and repair seems reasonable for thoracic superior vena caval injuries which look as if they may have stopped bleeding with or without the production of an associated hematoma.

Summary

A case is presented, with a review of the literature, of an infrequently reported superior vena caval laceration with survival from a posterior penetrating wound of the chest. Technical points in the care of these patients which may help to decrease the mortality are emphasized.

A bibliographic listing of references and citations will be found in Dr. Yadusky's reprints.

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Scabies is becoming rare in these days of potent detergents and a compassion for cleanliness. But the itch is still with us, often unrecognized because so many young doctors have never seen a case — or perhaps, never recognized one.

Animal Scabies In Human Hosts

Andrew Kallos, M.D./Kearny

Human infestations with mites are relatively common. But these parasitic diseases are not always recognized. The mite responsible for animal scabies in man (and also for human scabies) is *Sarcoptes scabiei*. Assigned to the lower echelon of the animal kingdom, it is a blood sucking organism that cannot survive on any other nourishment. *Sarcoptes scabiei*[1] belongs to the suborder Sarcoptiformes; Class Arachnida; Family Sarcoptidae.

Scabies In Animals

House pets, domesticated animals, rodents, and wild beasts are victimized by these pests. While the mites may be biologically dissimilar according to their respective host, they are morphologically alike, and the pattern of scabies varies little in the various animals. Sarcoptic mange (as the infestation is called) is quite familiar to the population at large. "Mange cure" is widely, though inappropriately, used for disturbances of the human skin and, especially, scalp. Beside *Sarcoptes scabiei*, Demodex folliculorum, Psoroptes, and Chorioptes can also cause mange. Detected early enough, it can be cured easily. Efficient external applications and internal medications are available. Remaining unheeded, it spreads over wide areas, leads to pyodermic infection and eczematization. This pyoderma may give rise to systemic involvement, and the eczema accompanied by continuous itching creates restlessness, lack of appetite, and loss of sleep. The reduction in weight in the cattle of a stricken herd[2] amounted to 15 per cent. Critical debility could also ensue, endangering the animal's life. Animal scabies is a real threat in veterinary medicine.

In man, two species cause scabies:

1. the Human mite, *Sarcoptes scabiei hominis*
2. the Animal mites, *Sarcoptes scabiei animalorum*.

Animal scabies in man, less significant clinically than human scabies, has been less studied. Because of their close relationship, the knowledge gained from human scabies facilitates the more thorough understanding of animal scabies as it unfolds in man. A review of the salient features of human scabies complements the picture of animal scabies in man.

Common Scabies

Common scabies used to be a widespread disease mainly among people with low hygienic standards, in the crowded quarters of institutions, and in slums. Disasters and wars would regularly bring on sudden increases. It accounted for a third of the admissions of some dermatologic clinics in the early decades of the century. Its incidence rose from 5 per cent in 1930 to 15 per cent during the war years,[3] to run into an almost complete eclipse by the mid 1950's. Reports from the United States,[4] Switzerland,[5] and Portugal[6] have borne out this trend. Today's medical students have little opportunity to become acquainted with the disease. Since the limited numbers that do arise remain confined to certain urban areas, most medical practitioners have to be reminded of scabies lest their diagnostic acumen become blunted.

In scabies the patient suffers with a great deal of itching, especially at night. He exhibits many scratch marks. There are the characteristic tunnels through which the mite works its way and the follicular papules where the mite hides. These nests are found in abundance in the favorite locations: the finger webs and the buttocks of adults, the face of children. Eczematization due to chronic infestation and incessant rubbing may ensue. Pyoderma (in contrast to scabies in animals) is a rare complication.

A less frequent but devastating form of human scabies, is called Norwegian scabies. This leads to a more extensive involvement of the cutaneous surface. This patient is really in trouble! It is estimated that up to 2,000,000 female mites ravage the patient's skin in Norwegian scabies as opposed to the few hundreds in common scabies and to a few dozens in animal scabies in man. The *modus vivendi* of the parasite is the same in Norwegian as in common scabies. The basic difference lies in the response of the host. The human integument counters with considerable keratotic proliferation in Norwegian scabies. Plaques of hardened skin are noted on the flexor and extensor aspects of the hands and feet, the buttocks, the elbows, the tip of the earlobes, and over the thyroid cartilage. These plaques develop in areas of pressure and stretching. They may crack and present painful deep fissures. The nails become distorted, crumbling, and discolored. Vegetations may develop. In the nodular form, small tumors appear throughout the infested areas. Total alopecia supervenes in long standing cases. Eczematization and intractable itching prevail. If a mentally retarded or catatonic patient has blunted sensorial perception, he may register no pruritus, and scratch or rub very little.

Humoral Reaction

The burrowing of the mite elicits no itching in scabies. The pruritus is experienced when the human host synthesizes humoral antibodies to the invader's secretion. This is why the rash induced by rubbing may not correspond to the sites of predilection of the mite. *Sarcoptes scabiei* extract injected into people who never had the disease (or had it for less than three months) evoked no reaction.[7] There was, however, marked reaction when the subject harbored the mite for more than three months; sensitivity increased as the infestation continued. Strangely enough, sensitivity to the mites is greater in common scabies than in Norwegian scabies, even though in the latter, there exist many more parasites, wider areas involved, and a stronger epidermal reaction. The presence of antibodies was corroborated by the passive transfer reaction of Prausnitz-Kuestner.[8] Paradoxically, in spite of the allergizing potential of *Sarcoptes scabiei*, no immunity develops in man or animal.[9]

Diagnosis

The parasites can be extracted from the skin with a sharp instrument and identified under the loup or the microscope. It is difficult to find them in Norwegian scabies: they are notoriously absent in its nodular form. Understandably, Norwegian scabies remains unrecognized on many an occasion until the physician (or some attendants) begin to itch. Infestation with *Sarcoptes scabiei hominis* may simulate psoriasis, keratoderma blennorhagica, tinea corporis, pityriasis rubra pilaris, papular urticaria, seborrheic dermatitis, or pediculosis. Psychiatrists are familiar with a parasitosis delusion, in which patients believe that they have scabies. Many of these patients, it has turned out,[10] actually did have the infestation prior to onset of the psychosis.

In doubtful cases, pathologic examination offers additional help. The parasite can often be detected buried in the epidermis. Eosinophilia may be observed in the dermal infiltrate and in the blood.

There is prompt response to treatment with precipitated sulfur or proprietary synthetics applied for 72 hours and followed by a cleansing bath. Prolonged, warm exposure is necessary for the transfer of the mites. Infested individuals must be isolated. The newer detergents coupled with the high temperature of

the washing machines are successfully eliminating clothing and bed linen as sources of reinfestation.

Animal Scabies In Man

Sarcoptes scabiei canis and related animal mites cause a multitude of infestations. But they have never gained much recognition in medicine, although animal scabies is of frequent occurrence in man. However, it is often undiagnosed because it appears unheralded and arouses relatively few complaints. Indeed, only four outbreaks in the United States have ever reached the medical literature: from New York,[11] Maine,[12] Minnesota,[13] and Tennessee.[14]

When the mites of mange venture on the human skin, it is a matter of a brief time before the expeditionary force perishes for the lack of new generations. In spite of this biologic inadequacy, animal scabies is contagious to man. A short contact with a sick pet suffices. The contact can operate through the clothing too. Clinical lesions, which develop within five days, consist of pinhead size pustules without a halo, with no tunnel, appearing individually over any part of the skin surface. There may be skin colored or erythematous macules or papules instead of the pustules.

Itching is experienced when barely a week has elapsed in the course of the eruption. Simultaneously scratch marks and scabs begin to form. The course rarely extends beyond three weeks, provided contact with the sick animal has ceased. If treated, a happy ending can be achieved rather rapidly.

Case Reports

The first victim in a family of six was a three-year-old girl. She had pimples in slowly growing numbers for a few days. Seven pinhead-size pustules were counted, one each on the right temple, the inner edge of the right ala nasi, the neck, the stomach, the left thigh, and two in the groins. The pustules were intact. No scratch marks were visible. Lymphadenopathy was not observed. The child appeared in excellent health. Contrasted with the mother's obvious concern, she was a contented bystander.

She was sharing the bed with her 10-year-old sister who, as yet, exhibited no lesions. The presenting picture was that of a mild bacterial infection and a folliculitis. An infestation with mites came into the proper focus with the history of a dog that had an extensive weeping eruption. A veterinary made a diagnosis of "mange." Because of the advanced stage of infestation the dog was destroyed. The three-year-old girl, who was the proud owner, had been holding on most of the time to her pet. The rest of the family, therefore, was much less exposed. Nonetheless, signs of infestation appeared later in the other members. Indeed, none save the 6-month-old baby escaped the disease. Itching was a late symptom in all the patients.

Actually, the most severe reaction developed in an uncle who did not even live in the house. He had a reaction over the abdomen because he had, for a fleeting moment, held the dog in his lap.

The noxious mite was easily demonstrated in several of the victims. Cleaning and disinfesting measures were instituted on the veterinary's recommendations. Application of an antipruritic-scabicidal cream relieved the condition within a few days.

This outbreak of animal scabies in the members of a household and an uncle offered a valuable opportunity to study the disease. This experience confirmed the fact that animal scabies is highly contagious to man and that its clinical course, if unchecked, could be very troublesome.

Unfortunately, it is not possible to gather much information from the patients with animal scabies since the follow-up, in most instances, is practically nil. Since the application of scabicide is followed by the rapid relief of the symptoms, the patients lose concern over their "trivial" infestation and fail to return. In the face of these developments, the physician finds his reward only in knowing that he had made the correct diagnosis and had instituted successful treatment.

A detailed list of bibliographic citations appears in the author's reprints.

703 Kearny Avenue

Any surgeon doing an appendectomy should, D'Ambrosio suggests, explore for a Meckel's diverticulum — and here he explains why.

Meckel's Diverticulum*

Report of a Case

Victor D'Ambrosio, M.D./Murray Hill

Meckel's diverticulum is a vestigial remnant of the omphalo-mesenteric duct. It presents itself usually as a finger-like outpocketing from the anti-mesenteric border of the ileum. Lavater first described this diverticulum in 1671. But Johann F. Meckel in 1764 first grasped its embryologic and anatomic significance.

Incidence: Of 17,000 autopsies surveyed by Rich,[1] Meckel's diverticulum was found in 124 cases — an incidence of 0.73 per cent. However, in 1933, Harkins[5] reported an incidence of 1.4 per cent in the autopsies he performed. Some of the latest reports give figures as high as 3 per cent of all the patients coming to autopsy. It is three times more common in males than in females. Best current estimates are that Meckel's diverticulum is present in 2 to 3 per cent of the total population. About half of those who become symptomatic do so before the age of two.

Meckel's diverticulum and the abnormally mobile cecum and sigmoid give symptoms in the adult much as in children.

Location: Nygaard and Walters[2] point out that Meckel's diverticulum, theoretically, may occur anywhere between the cardia of the stomach to the rectum. Usually it is located 3 to 4 feet from the ileo-colic valve.

A 30-year-old man entered Overlook Hospital with the admitting diagnosis of "acute abdomen." He had had an appendectomy at the age of 8. He had been overseas, and during that time noted an increasing number of post prandial abdominal cramps, lasting 10 to 15 minutes.

One day, in a restaurant, he and three friends had frankfurters and beer. All developed diarrhea, cramps, and vomiting. He was told he had "gastro-enteritis." By the third day, he felt worse. When he then entered the hospital, the abdomen was rigid, and no bowel sounds were present. Scout films of the abdomen revealed small scattered air pockets, appearing to be outside the bowel lumen.

The laboratory report at this time showed 24,400 white blood cells, of which 6 per cent were lymphocytes. The monocytes were 2 per cent to 15 per cent bands. Hemoglobin was 17.8 and hematocrit was 50. The Blood Urea Nitrogen was 32. The specific gravity of the urine was 1034, with 2-plus albumen. There was



Figure 1. Diverticulum is exposed and the apex shows leakage of intestinal content at the tip of the clamp.

no glycosuria. A culture of the peritoneal fluid revealed Escherichia coli.

A laparotomy was done. He had a generalized peritonitis with a large hard mass in the right pelvis. This was adherent to the anterior abdominal wall. It turned out to be a huge Meckel's diverticulum, measuring 3½ by 4 inches. (see Figure 1). A leaking perforation was present at its tip.

This diverticulum was within 4 feet of the ileo-cecal valve, arising *not* from the usual anti-mesenteric border but instead from the lateral wall of the small bowel. (see Figure 2)

Resection was carried out between two clamps and edges inverted, with one layer of 000 chromic and one layer of 000 silk interrupted sutures.

* From the Surgical Service of Overlook Hospital, Summit, N.J.

On the fourth post-operative day, his temperature dropped to normal. But on the eighth post-operative day, the temperature rose to 101 and the pulse to 100. On this day, he developed acute peritoneal cellulitis.

He was maintained on tetracycline until the eleventh day, when this was discontinued. Then we gave crystalline penicillin and streptomycin intramuscularly. The temperature returned to normal within 24 hours.



Figure 2. You can see the take-off of the diverticulum from the lateral aspect of the small bowel wall.

Complications: A Meckel's diverticulum can cause obstruction by impaction of the diverticulum, gangrene of the wall, perforation, and peritonitis. Our patient exhibited a truly rare complication: the neck of the diverticulum was enlarged to almost the size of the small bowel, but viable. The cavity was packed with fecal content and multiple calcifications were found in several areas. (See Figure 3)



Figure 3. Note the size of the diverticulum, the thickness of the wall, and the multiple large calcifications. Most of the calcified areas were removed with difficulty by the pathologist.

The tip of the diverticulum had perforated and given origin to pneumo-peritoneum and peritonitis with paralytic ileus. The acute fecal impaction resulted in impairment of the blood supply to the wall. This was followed by perforation and peritonitis. All this took place in a diverticulum, which had gradually (and probably over the years) become dilated and packed with fecal content. The neck was empty. No twisting action had taken place. Yet, gangrene and perforation had developed. In figure 1, note the thickness of the diverticulum wall and its adherence to the bladder.

Owen and Finley[6] stated that heterotopic tissues within the wall of the diverticulum predispose to disease of the diverticulum, although heterotopic tissue is not a disease in itself. In the previously reported cases in which enteroliths were present (and in our own case) the absence of any ectopic secreting tissue was one of the features. This histologic feature may well play a prime role in the formation of enteroliths.

In all, only three cases have been reported where the enterolith (after organizing in the diverticulum) had migrated into the small intestine distally, causing acute intestinal obstruction. Only 14 cases of Meckel's diverticulum with enterolith formation within the lumen have been reported in the world's literature. Our case has several aspects of interest in that it represents both groups.

One can theorize that the enterolith forms in Meckel's diverticulum as a result of fecal impaction, which progresses over the years (almost over the lifetime) to full stone formation. Our patient did not wait long enough so that full enterolith could finally be organized. Instead, the Meckel's diverticulum found in him at an early stage of calcification became *impacted*, and by way of vascular impairment went into gangrene, perforation, and generalized peritonitis (small pneumoperitoneum).

Another distinctive feature in our patient was the presence of a small pneumoperitoneum. It is worth noting, too, that our patient had had an appendectomy (at age 8) and the Meckel's diverticulum was then missed.

Conclusions

1. Whenever an appendectomy is done (regardless of whether or not the appendix is diseased), exploration for Meckel's diverticulum must be carried out. If a diverticulum is found and not removed, the patient should be informed about possible later consequences of this anomaly.

2. Our case demonstrates the early process of calcification, which can lead to the formation of large enteroliths.

3. The absence of ectopic secretory tissue is feature of interest in this case.

4. A small pneumoperitoneum in a young patient with "acute abdomen" plus the roentgen picture of a paralytic ileus should alert the doctor about the possibility of Meckel's diverticulum.

5. A clinical history of intermittent, recurrent episodes of "crampy" abdominal pains merits careful review plus a small bowel series.

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Sold by the Woman's Auxiliary to The Medical Society of New Jersey for the benefit of MSNJ's Medical Student Loan Fund. Orders may be sent to the State Auxiliary Office, P. O. Box 904, Trenton, New Jersey 08605.

The traditional treatment of diabetes insipidus is by pitressin tannate or pituitary snuff. It has been found, however, that lysine-8-vasopressin spray is just as effective without the discomfort associated with the older treatment.

Treatment of Diabetes Insipidus with Vasopressin Spray

Richard L. Fogel, M.D./East Orange

Diabetes insipidus of neurohypophyseal origin is the result of a deficiency in the production or release of antidiuretic hormone. The major findings are polyuria and polydypsia. Treatment has consisted of replacement utilizing either pitressin tannate-in-oil, or posterior pituitary snuff. Both preparations have been associated with significant untoward reactions.[1] Since the chronic nature of diabetes insipidus necessitates an indefinite course of therapy, the recent availability of a synthetic preparation without reports of marked side effects is certainly a welcome development.

Several authors[1,2,3,4] have reported experience with the recently synthesized 8-lysine vasopressin, administered in the form of a nasal spray. Additional experience with the use of this drug in three patients with diabetes insipidus is the purpose of this report. Its use in a pregnant patient with diabetes insipidus has been recorded only once before: by Dingman *et al.*[1]

Case One

A 27-year-old woman was found to have "idiopathic" diabetes insipidus after presenting with complaints of extreme thirst, excessive urination, and weight loss. Standard procedures (including a Hickey-Hare test) confirmed the impression of antidiuretic hormone deficiency. She was initially placed on posterior pituitary snuff; then, injectable pitressin tannate-in-oil with good results. However, mucous membrane irritation precluded the use of the snuff, and the repetitive nature of the treatment made continued therapy difficult. We then tried 8-lysine vasopressin spray, administered 2 or 3 times daily. This proved to be quite successful. The patient became pregnant; therapy was continued without difficulty and without change in dosage.

Case Two

A 44-year-old man was noted to have panhypopituitarism and neurohypophyseal diabetes insipidus on the basis of appropriate endocrine studies. Initial complaints were constant thirst, frequent urination, weight loss, and chronic fatigue. Management of the diabetes insipidus was simply instituted with the use of the 8-lysine vasopressin spray. Previously he had been controlled with injectable pitressin tannate-in-oil with supplemental thiazide preparations. This therapy was not thereafter required. Two to three sprays per 24 hours were needed to control symptoms. No nocturia occurred.

Case Three

A 14-year-old boy was found to have diabetes insipidus of neurohypophyseal origin utilizing standard test procedures. He was fairly well-controlled with injectable pitressin tannate-in-oil. However, an additional evening dose was frequently necessary to prevent enuresis. Here, 8-lysine vasopressin spray was successfully substituted for the pitressin though an evening dose was still required to prevent enuresis. Four to six sprays per 24 hours were needed. No side effects have been noted. Weight gain, restoration of muscle strength, and general well-being have resulted.

Conclusion

Lysine-8-vasopressin nasal spray was successful in controlling the manifestations of diabetes insipidus in three patients with demonstrable neurohypophyseal insufficiency. The dosage varied from two to six sprays per twenty-four hours. Nocturia was not a problem. Although reports of nasal stuffiness[1] and occasional abdominal cramping[2] have been recorded in

the literature,[3] no such side effects were noted in this series.

In view of the known frequent and sometimes severe side effects, as well as the discomfort associated with the chronic use of posterior pituitary snuff and pitressin tannate-in-oil, it is expected that lysine-8-vasopressin spray will become the treatment of choice in diabetes insipidus due to neurohypophyseal insufficiency.

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299 South Harrison Street

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Open reduction by interosseous wiring is the aggressive management technic favored by the Peer-Walker group in facial fractures.

The Treatment of Facial Fractures

Robby Meijer, M.D./East Orange

During the last decade, much has been written about fractures of the facial bones. Yet one cannot help but notice the unconcerning attitude generally shown about these fractures. Victims of high speed accidents are often vigorously treated for fractures anywhere else on the body, while in the same patient a fractured zygoma or maxilla is initially ignored and then often inadequately treated. Fractures of the facial bones heal within a few weeks, after which adequate reposition of the bony fragments requires much more of the surgeon's skill.[1] Part of medical progress is the aim for perfection. Standards of an "adequate" result of repair 20 years ago do not stand up to date. Reviews of such cases show imperfections of reduction by methods like antral packing or the use of external fixation devices.[2] Adams[3] made the first step towards better management of fractures of the facial bones with his introduction of wire fixation methods. Actually, only very few cases are in the need of external appliances, whether of the plaster head cap type or any of the more recently proposed metal frame "halos." *Internal* fixations by means of direct interosseous wiring and suspension wires are most effective, less cumbersome, and allow the patient a faster recovery.

Fractures of the nasal bones. This is the most frequently seen facial fracture. X-rays are of little value in diagnosis. However, for medicolegal reasons they are indicated in every case of suspected fracture of the nose. Closed reduction, done meticulously, usually gives excellent results. Careful attention should be paid to the nasal septum. Fixation of the fragments is done with intranasal packings of Oxycel cotton with adaptic or Carbozine gauze. Often a dental compound splint is used externally. If healing of the fracture is allowed without any or inadequate reduction, a submucous resection and rhinoplasty are usually necessary to eradicate the fracture sequellae.

Fractures of the mandible. The diagnosis of these fractures is usually simple to make clinically and is generally confirmed by x-ray. A second, contralateral fracture line is not infrequently present and must be looked for. Tomograms of the temporo-mandibular joints are indicated when there is pain on opening the jaw. When dentition is normal, the treatment for most mandibular fractures is simply the application of Erich-type of arch bars and intermaxillary fixation with rubber bands. In a partially or totally edentulous patient (or in any case of questionable satisfactory reduction or fixation) an open reduction with direct interosseous wiring of the fracture sites is done, usually through a small external incision. When made in the proper place and closed in the proper way, these scars are rarely noticeable. Teeth in the line of fracture are usually not sacrificed since they are often helpful in the fixation and stabilization of the fracture. Failure to obtain adequate reduction and fixation leads to non-union or malocclusion and other correlated dental problems.

Fractures of the zygomatic arch. The resulting deformity is usually seen and almost always palpable. Opening of the jaw is limited with pain in the affected area. An x-ray in the Water's view or 30 degree fronto-submental

projection will confirm the diagnosis. The classical reduction of this fracture is through the Gillies' approach. An incision is made in the hairline and the temporal fascia exposed and incised. An elevator is introduced, underneath the fascia, going downward until it reaches under the fracture site. The depressed part of the arch is then elevated. Fixation is rarely necessary. If it is, this is done through an incision immediately overlying the fracture and by direct wiring of the fragments. If no reduction is done, an external deformity remains with the patient being unable to open the mouth completely.

Zygomatico-maxillary fractures. It is in this group that the treatment given is often inadequate or deferred too long. The patient's general condition may warrant treatment for shock or observation for brain injury first. In more severe cases, tracheostomy is often necessary. Once the patient's condition has stabilized the ideal time for repair has arrived. The tracheostomy is then helpful and should not be discontinued prematurely. Depression of the infra-orbital rim, flattening of the malar eminence, loss of sensation of the cheek skin, etc. are clinical evidence of a zygomatico-maxillary fracture and x-rays are indicated. Usually the Water's view will tell the story, but tomograms will reveal more details, especially about the condition of the orbital floor.

The treatment that will afford the best reduction is open reduction with direct interosseous wiring of the fragments and (where necessary) with fixation by means of suspension wires. To reach the fracture sites, incisions are made in the lateral part of the eyebrow, in the lower eyelid and in the upper buccal sulcus and wherever else it seems necessary. Antral packing is rarely used. The floor of the involved orbit is routinely explored. Silastic sheeting is used if the condition of the floor warrants repair. Long-term re-evaluation of patients with zygomatico-maxillary fractures where close to perfect reduction has not been obtained and where the obtained reduction has not been maintained by direct interosseous wiring showed unsatisfactory results in more than half of the cases.[4] Among these long term flaws were unsatisfactory cosmetic appearance, persistent diplopia, limitations of the jaw motions, sinusitis, and persistent numbness over the cheek.

The "blowout" fracture. This term vividly describes an injury of the floor of the orbit following a direct blow to the orbital area. This can occur singularly, or as part of a fracture of the zygomatico-maxillary compound. An x-ray diagnosis may be obtained by tomograms in Water's position. However, a negative x-ray finding does not exclude this fracture. Diplopia in the upward gaze and enophthalmus with disappearance of the upper lid fold are indications for exploration. A positive Converse's traction test is another one. When a shattered floor of the orbit is found with orbital contents protruding into the maxillary antrum, repair was usually done with cartilage grafts or iliac bone grafts. However, lately Silastic sheeting has been used exclusively with very satisfactory results and a decreased morbidity. Failure to repair a blowout fracture will result in persistent enophthalmus with the involved eye often remaining at a lower level than normal, which may be the cause for a persistent diplopia. Secondary repair consists of elevating the orbital floor by means of bone grafts or Silastic but satisfactory results can often not be obtained.

Summary

A plea is made for a more aggressive approach toward the treatment of acute fractures of the facial bones. Open reduction with direct interosseous wiring is favored.

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120 Halsted Street

The controversy about hereditary factors in tumors continues to rage. Cases like this seem to underscore the genetic component.

Multiple Bilateral Mammary Fibro-Adenomata In Identical Twins*

George T. Pack, M.D./New York
John A. Ianacone, M.D./Paterson

Twins occur about once in ninety human births. Some 25 per cent of human twins are monozygotic; i.e., developing from a single ovum and, therefore, possessed of the same genes. In general, it may be stated that, even in twins, such nongenetic influences as environmental factors and exposure to carcinogenic agents are more important in the induction of cancer than is the genetic tendency. Accumulative evidence would suggest that heredity acts more in the localization of the tumor in twins than in any predisposition toward a neoplastic disease. An example[4] is a pair of 71-year-old male identical twins possessing the same blood grouping. Both developed carcinomata of the gastric cardia in the same 12-month period. Other examples have been recorded by Madge Thurlow Macklin,[2,3] who observed simultaneous carcinomata in the left breasts of identical twins aged 89 years and bilateral cancers of the breasts in another set of monovular twins. Other examples of tumors in identical twins are patients with retinoblastomata, instances in which both twins had cerebellar tumors, testicular teratomas in both members of an identical pair, and the occurrence of malignant ovarian teratomas in monozygotic twin sisters.

A critical study on the development of cancers in twins is that of Busk, Clemmesen, and Nielsen,[1] who followed 185 pairs of twins, of whom 52 were monozygotic. The calculated expected values for the number of times both twins should be affected (using cancer risk in the general population for comparison) revealed that the expectant concordant number for the 52 monozygotic twins was 5; the observed number was 7 pairs. The expectant concordant number for the 133 dizygotic twins was 9.2 pairs; the observed number was 7 pairs. Of the 7 concordant monozygotic twins, 4 had cancers in the same organ. Of the 7 concordant dizygotic twins, only one had cancer in the same organ. Therefore, they concluded that the ratio of frequency of localization was 4 to 1 in the monozygotic over the dizygotic twin frequency.

Certain conclusions, more general than specific, may be considered logical in this relationship of tumors occurring in twins: (1) Tumors affect both members of a monozygotic pair more frequently than both members of a dizygotic pair. This ratio is said to be 4 to



Figure 1. Monozygotic twins, aged 47, with multiple fibroadenomas in their bilateral breasts.

* From the Lendrim Tumor Clinic of the Paterson General Hospital, Paterson, N.J.

1. (2) Tumors of the same type and in the same organ in both twins occur more frequently in monozygotic than in dizygotic twins. (3) The age of onset is more nearly identical for monozygotic than for dizygotic twins. (4) The noncancerous twin of a pair should be kept under observation for a long period to ascertain whether the degree of concordance is greater than occurs in siblings who are not twins.

Two sisters, now aged 47 years, had the appearance of identical twins in their physiognomy, obesity, and body conformation, etc. (Figure 1). Roberta was 5 feet tall and weighed 203 pounds. Her blood group was O with the Rh factor positive. In 1944, she had a large intracanalicular fibroadenoma removed from the left breast. In 1952, another intracanalicular fibroadenoma was removed from the right breast. The locations in the breast were at 9 o'clock in the right breast and at 3 o'clock in the left breast, at the extreme outer segments. Her sister Nellie was 5 feet 2 inches tall and weighed 220 pounds. Her blood group was O and the Rh factor positive. In 1946, she had an intracanalicular fibroadenoma removed from the left breast. In 1965, she had two similar fibroadenomata removed from the right breast and two fibroadenomata removed from the left breast, of which one was an intracanalicular fibroadenoma and the second a benign so-called "cystosarcoma phylloides" (giant intracanalicular fibroadenomyxoma) (Figure 2). The fingerprints of the sisters, aged 47, were identical. Soft-tissue mammograms were done only on Nellie. These bilateral mammograms revealed two rounded nodules in the substance of the right breast, one larger than the other, with numerous calcific deposits (Figure 3). In the left breast the mammogram showed two spherical nodules, one about 5 centimeters in diameter. Both contained calcific deposits. The operations in both instances consisted of local excision of the benign tumors. There was no history of other neoplastic diseases nor was there any familial history of such tumors.

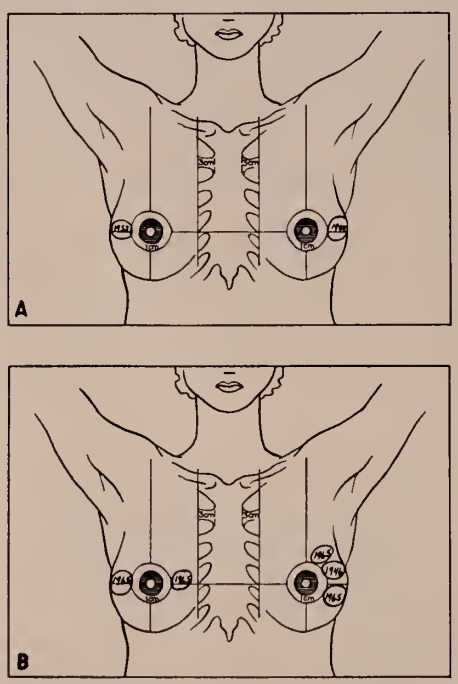


Figure 2. Regional distribution of tumors in twin sisters. *A*. Roberta. *B*. Nellie.

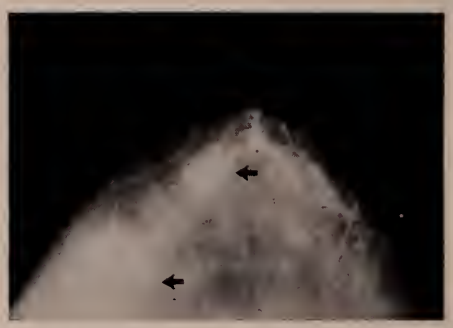


Figure 3. Mammogram of right breast of Nellie.

These case reports are significant because of the proved monozygotic type of twins, with similar blood groups, similar fingerprints, identical facial resemblance, and similar body habitus. Fibro-adenomata of the breast are presumably congenital tumors, developing from cell rests. They do not make their clinical appearance usually until after the onset of puberty. Thus, the findings in these sisters are pertinent in that both breasts in each sister contained benign tumors of similar histogenetic type. The locations in the outer quadrants of both breasts were the same in the identical twins.

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310 Fifth Avenue (Dr. Ianacone)

As the locus of our nation's first viable workmen's compensation law, New Jersey has a proud heritage in the field of industrial rehabilitation.

Rehabilitation Of The Disabled Worker

I. An Overall View of Rehabilitation and Workmen's Compensation in New Jersey.

Monroe Berkowitz, Ph.D./New Brunswick

This is the first of a series of articles on workmen's compensation and industrial rehabilitation in our state. If this, or any succeeding, article stimulates any questions, please send your question to Jarvis M. Smith, M.D., Medical Director, Rehabilitation Commission, Trenton, New Jersey 08625.

The information in the monograph was compiled by Dr. Berkowitz, Chairman of the Department of Economics at Rutgers State University. It was developed from reports of the New Jersey Institute on Workmen's Compensation, Rehabilitation, and Employment. Some eight panels were set up under leaders in the field, with additional help from resource specialists, including Mrs. Beatrice Holderman, Director of the New Jersey Rehabilitation Commission; Mr. Thomas L. Franklin, Acting Director, New Jersey Division of Workmen's Compensation; and Mr. Charles F. Reilly, Deputy Director, Division of Employment Security. Many recommendations were made and will be outlined in this series. It is hoped that these papers will help the doctors of New Jersey to a better understanding of the disabled worker and his rehabilitation to gainful occupation.

Jarvis M. Smith, M.D.
Medical Director
N. J. Rehabilitation Commis ion

New Jersey is a state with a heritage of concern for the injured workman. Although it is not easy to disentangle conflicting claims, it is true that our workmen's law is the oldest statute in point of enactment that has remained in effect. On April 4, 1911, Governor Woodrow Wilson signed a bill establishing a pioneer workmen's compensation law. It became effective on July 4, 1911.

New Jersey is also a pioneer state in rehabilitating the injured workman. Our first rehabilitation law, passed in 1919, covered all physically disabled persons who were, or might be expected to become, totally or partly incapacitated from remunerative employment. Significantly, the term "rehabilitation" was construed to include physical restoration as well as vocational training and placement. Thus, from the very beginning, rehabilitation efforts in New Jersey avoided any artificial distinction between physical restoration on one hand and guidance, training, and placement activities on the other.

There was an intimate and direct relationship between the Rehabilitation Commission and the Workmen's Compensation Division. The closeness of these two agencies needs to be emphasized, because New Jersey had achieved by 1919 what some states are still just trying to achieve today. In 1919, the first state diagnostic industrial surgical clinic was opened in Newark in the same building that housed the workmen's compensation hearing rooms and the Employment Service.

In 1920, Commissioner of Labor Lewis Bryant reported on Rehabilitation in New Jersey to the International Association of Industrial Accident Boards and Commissions, the professional organization of compensation administration. Colonel Bryant said: "It is our purpose to have at these gatherings a representative of the training session of the rehabilitation operation, so that the problem of return to industry of each injured worker may be studied by experts and followed up either by vocational training or intelligent placement of the worker in the industrial occupation for which he is physically, mentally, and,

by past experience, best capable of filling." By 1922, four additional clinics were established in conjunction with the compensation centers in Jersey City, Camden, Trenton, and Paterson. In 1927, an occupational therapy unit (known as a curative workshop) was established in conjunction with the Newark clinic.

Achievements in New Jersey in this field have not been continuous. The compensation program and the rehabilitation programs grew apart. By 1945, the rehabilitation-compensation clinics were abandoned. It has been only in the last several years that the agencies have worked cooperatively to achieve what traditionally is the goal of workmen's compensation: rehabilitating the injured workman.

In 1956, a program was initiated to improve efforts to rehabilitate workmen's compensation claimants. A person was assigned within the Division of Workmen's Compensation to review the referrals being made by the hearing officials to the Rehabilitation Commission. A Vocational Rehabilitation Administration pilot project began in 1959, to demonstrate how industrially injured workmen might be effectively rehabilitated through the cooperation of the Rehabilitation Commission, the Workmen's Compensation Division, social workers, insurance carriers, physicians, and lawyers. The outstanding results of this pilot program led, in 1963, to the establishment of a rehabilitation unit in the Division of Workmen's Compensation to serve industrially injured workmen. In its very first year, through the work of this unit, 201 industrially injured workmen were able to return to remunerative employment. Their first year's earnings after rehabilitation are estimated at $768,820.

New Jersey's statute covers a higher proportion of the labor force than laws in most other jurisdictions. There are no exceptions for employees who work in small establishments; therefore, employers with but a single worker are covered with the exception of casual workers, and the law is very restrictive in defining these. Even baby-sitters and occasional household help qualify as employees under the law. Agricultural workers and domestic workers, however, are not required to be insured. Many employers in New Jersey are not aware of their potential liability in the event of an accidental injury. New Jersey (together with 33 other jurisdictions) provides full coverage for all occupational diseases which are considered in the same way as accidental injuries.

In New Jersey it is mandatory for all employers (with the exceptions noted previously) to insure their liability for possible workmen's compensation payments with a private insurance company; or provide evidence of their own ability to self-insure. New Jersey has neither a competitive nor an exclusive state insurance fund for workmen's compensation.

In the country as a whole, roughly speaking, only about 60 per cent of the insurance premiums paid to commercial underwriters of workmen's compensation insurance is returned to the workers in the form of either cash benefits, or medical and other services. Approximately 40 per cent is allocated for the various expenses of the private insurance carriers. These percentages are comparable in New Jersey.

In 1964, some 2,890 people were rehabilitated by the New Jersey Rehabilitation Commission. Of this number, 201 had been industrially injured. During that time 8,900 persons were receiving on-going restorative or training rehabilitation services. It is estimated that the 2,890 persons rehabilitated in 1964 represent wage earnings in excess of $7,500,000 the first year after their rehabilitation. For every dollar spent spent on rehabilitation, 5 to 7 dollars are returned in taxes. Obviously, such a program is economically sound.

The Vocational Rehabilitation Program is a federal-state partnership in rehabilitating the physically and mentally handicapped. The program requires concentrated, coordinated effort. It is a state and community responsibility. Its dividends are significant in terms of personal dignity for the individual as a productive, independent member of society.

New Jersey is distinguished from many other states in that a higher proportion of its cases are settled at the formal hearings stage. In 1962, about 40 per cent were settled at formal hearings; 22 per cent were settled by voluntary payments at informal hearings; and 38 per cent were closed by voluntary payments made through direct settlements. A little over half (55 per cent) reflect payments for temporary disability exclusively. When the Workmen's Compensation Act was passed, it was felt that most of the cases would be settled voluntarily once the standards were set in the law. Actually, relatively few of the cases are settled at the direct settlement stage. This has a bearing on the whole problem of rehabilitation. Once the case proceeds further than this, more time is necessary and the resulting hearings may have an adverse effect on the rehabilitation potential of the injured workman.

In January 1958, the Division began the Direct Settlement Review Program. Clerical personnel in the Central Office examined reports of direct settlements submitted for filing by the employers and carriers. Reports which indicated that further inquiry was not necessary were sent to the Workmen's Compensation referee for review. If a referee, based upon the report of settlement, feels that settlement is adequate, he closes the matter at this stage. If he concludes differently, the matter is scheduled for a special informal hearing. The referee has the benefit of all medical reports, his personal observations, plus any information he may gain by questioning the injured worker. He also has the views of the employer and his representative. After gathering all relevant data, the referee then makes a judgment as to whether the award is adequate or whether the extent of disability is greater than originally reported. If the disability is greater, he recommends that additional compensation be paid. If either party chooses not to accept the referee's conclusion, then the injured worker is advised that he is entitled to file for a formal hearing.

The full dividends of this Direct Settlement Review Program cannot be expressed in statistics alone. It comes as close as anything in New Jersey to a review by the administrative agency of the adequacy of medical treatment as well as cash benefits. The Direct Settlement Review Program has resulted in the type of review which, many feel, should be routine in any Workmen's Compensation agency. Direct settlements have not significantly reduced the number of cases which go through the fully-litigated stages and, as we shall see, this can be a problem in the early rehabilitation of the injured workman.

Under the New Jersey system (which places such emphasis on the "whole-man" theory) physical disability is compensated as such. The result is that a high proportion of awards result in permanent partial-disability payments. The benefit levels and the dispositions made of the compensation dollar are, of course, of over-riding importance. But concern over these matters should not block consideration of the significant problems relating to the rehabilitation of the worker. One of the refreshing things about this New Jersey Institute was an attempt to isolate and discuss some of these other problems.

In the next article, we shall discuss "Litigation as a Barrier to Rehabilitation."

Rutgers University
Bureau of Economic Research

AMA ANNUAL MEETING

June 26-30 **Chicago, Illinois**

STATE ACTIVITIES

Trustees' Minutes

April 17, 1966

A regular meeting of the Board of Trustees was held in Trenton on Sunday, April 17. Detailed minutes are on file in the county office for your full information. Here is a résumé of the significant actions taken.

AMA Dues' Increase . . . Designated Dr. Joseph Donnelly, chairman of the AMA delegation, and the MSNJ Office Manager, as official representatives to accept the AMA's offer for a review and explanation of the budget, in furtherance of the Society's attempt to justify an increase in AMA dues.

Burlington County . . . Approved in principle the following policy with respect to community action programs, as adopted by the Burlington County Medical Society:

> Physicians are free to volunteer their services but the Burlington County Medical Society feels that budgetary provisions should be made for adequate compensation for physicians' services in view of the continuing nature of the programs.

Hearing and Speech . . . Approved the recommendation of the President-Elect that the Committee on Hearing and Speech be deactivated as of the beginning of the new fiscal year 1966-67.

Commissioner of Health . . . Received with gratification a letter from the Commissioner of Health commending MSNJ for its cooperation in the "Comparative Medicine and Human Health Symposia" recently held under the auspices of the Health Department.

Animal (Medical) Research . . . Endorsed the policy statement of the New Jersey Public Health Association, in which recommendation is made that animals assigned to the pens and shelters in New Jersey for the purpose of humane destruction be hereafter made available for medical research, thus eliminating the profit-motive for those given to stealing and vending pets.

. . . Designated Dr. Edwin H. Albano of East Orange as the Society's official representative to work with the New Jersey Public Health Association, the New Jersey medical schools, universities, and research institutions in group discussions to consider formation of a New Jersey Society for Medical Research.

Special Assessment . . . Approved the recommendations of the Finance and Budget Committee that the House of Delegates vote a special per capita assessment of $5.00, as a contribution to the Medical Student Loan Fund, to be available for loans in 1966-67 (50%); to the Bicentennial Fund (25%); and to the Library of the Academy of Medicine of New Jersey (25%); and that the special per capita assessment apply equally to all dues-paying members.

1966 Dues . . . Approved the recommendation of the Finance and Budget Committee that the per capita assessment for 1966 be set at $40.00.

AID Program . . . Agreed to recommend to the 1966 House of Delegates that the AID program be continued for another year at least, to afford sufficient time to prove itself.

AMA-ERF . . . Directed that the presentation of two checks representing the AMA-ERF allocation this year to two medical schools in New Jersey be made at the first session of the House of Delegates in Atlantic City; directed that the Deans of the New Jersey College of Medicine and Dentistry and of the Rutgers Medical School be invited to come to Atlantic City for the presentation.

Academy of Medicine . . . Designated a committee of the Board to explore with a similar committee of the Board of the Academy of Medicine of New Jersey their detailed proposal for an intimate relationship and closer cooperation.

Administrative Secretary . . . Reviewed the many details and arrangements for the Bicentennial annual meeting which had been worked out by the Administrative Secretary-Convention Manager prior to her illness; directed that Mrs. Madden be appropriately thanked for the fine planning and efficient procedures she has brought to this — as well as all other — annual meetings.

Membership Directory . . . Agreed that the added expenditure of 40¢ per copy for a thumb-index of counties in the 1966-67 *Membership Directory* could not be justified, and thus should be eliminated.

VA Contract . . . Authorized Dr. Joseph R. Jehl as the Society's representative in signing the VA contract with the government this year.

Contribution to Academy . . . Referred to the House of Delegates a resolution from the Academy of Medicine of New Jersey requesting that MSNJ contribute to the Academy and its Library; recommended that a contribution to the Academy in 1967 be the same as that adopted by the House for 1966.

WANT TO BE A BOOK REVIEWER?

Members sometimes ask what it takes to qualify as a book reviewer for this JOURNAL. The reviewer keeps the book. We need doctors who will send in the reviews within five weeks after getting the book. We can use not only specialists but also GP's, since many medical texts are aimed at family doctors. If interested, send in your name, address, kind of book you would like to review, plus assurance that you can have the typed review back within five weeks. Ask for our reviewers' instruction sheet. Write: Editorial Office, The Medical Society of New Jersey, P. O. Box 904, Trenton, New Jersey 08605.

State Legislation

At its meeting on March 20, the Board of Trustees approved the recommendations of the Council on Legislation, as indicated, on the following bills.

All bills thus marked (*) are identical with measures of last year — or preceding years — whose positions are identical.

S-93 —To provide immunity from liability to respond in damages as a result of acts rendered in good faith providing emergency first-aid and rescue services to paid police and fire department members. *Approved*

S-103—To include the State Department of Health as an enforcing agency for violations of established standards for use and construction of sewerage facilities. *Approved*

S-123—To permit boards of health to compel owners, lessors, etc. in charge of buildings used for stores, factories, or businesses to provide a 68 degree heating temperature between September 15 and May 15. *No Action*

*S-133—To prohibit use of force in taking samples to
*A-134—determine alcohol content of persons accused of driving a motor vehicle under the influence of intoxicating liquor. *Approved*

*S-142—To include under the scope of laws dealing with the practice of optometry any who offer and market for sale at retail to the general public spectacles or eyeglasses containing other than plano lenses. *Disapproved,* because it denies to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and discriminatory.

S-166—To revise generally the statutes governing food and drugs. *Approved*

S-177—To authorize the trustees of the New Jersey
A-330—College of Medicine and Dentistry to acquire for their use the Jersey City Medical Center. *No Action*

*S-179—To eliminate the need for a physician's certi-
*A-365—ficate in connection with an absentee ballot for temporary disability. *Disapproved,* because it would encourage self-diagnosis.

*S-183—To provide for education of students in the
*A-109—medicine and dentistry professions. *Approved*

*S-194—To regulate the practice or profession of removing superfluous hair from the body through registration and licensing of electrologists by the Board of Medical Examiners. *Approved*

S-210—To provide for the disposition of human remains and parts thereof by written instrument signed by the donor and two witnesses. *Approved*

A-21 —To provide for the special education of handicapped children. *No Action*

A-22 —To create the "Criminal Injuries Compensation Act of 1966" to provide compensation for innocent victims of crimes. *Approved*

Attention was called to the fact that this bill would establish the Violent Crimes Compensation Board in the Department of Law and Public Safety, composed of three citizens appointed by the Governor with the advice and consent of the Senate. To assist the Board in determining the nature, extent, or cause of personal injury or cause of death compensable under this bill, the Board is obliged to maintain a panel of impartial medical experts. According to the bill, "the specialty to be represented on the panel and the number of experts in each specialty shall be determined jointly by MSNJ and the Board. The experts to serve on the panel in the several specialties shall be designated by MSNJ."

*A-41 —To require "semi-private" room care for injured workmen under the Workmen's Compensation Law. *Disapproved,* because it is based on the unsound premise that the quality of medical and nursing care in hospitals is controlled by the expensiveness of the accommodations.

*A-42 —To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease, or tuberculosis shall be deemed to be an occupational disease. *Disapproved,* because it involves diagnosis by legislative enactment rather than by medical investigation.

*A-51 —To establish presumption in certain illnesses of firemen and policemen. *Disapproved,* because it involves diagnosis by legislative enactment rather than by medical investigation.

*A-54 —To give the Commissioner of Banking and Insurance authority over rates of payment made by medical service corporations. *Active Opposition,* because it would empower the Commissioner of Banking and Insurance to fix fees to be paid by MSP to participating physicians and would therefore constitute an unwarranted and unjustifiable denial of the fundamental right of the physician to set his own fee for professional services rendered, thus threatening the operation of the Plan, in disregard of the best interest of the approximately two million people of New Jersey who are its subscribers.

*A-116—To require crankcase ventilators on cars manufactured after June 30, 1967. *Disapproved,* because there is no provision for inspection or enforcement of the law by means of a supervisory or responsible body.

*A-126—To require the use of humane methods in the slaughter of livestock. *No Action*

*A-137—To permit the Air Pollution Control Commission to establish standards of quality of fuels and allowable emission of contaminants from motor vehicles and to establish standards for types of control devices or engine modifications for motor vehicles. *Approved*

*A-140—To reorganize and continue an eleven-member Air Pollution Control Commission in the State Department of Health. *No Action*

A-153—To increase state payments to county welfare boards for medical assistance to the aged to 75% in place of 60% of the balance of aid expenditures after deduction of allocated federal funds. *No Action*

A-161—To amend the regulations concerning physical connections in the transmission of public water supplies. *Approved*

*A-162—To provide that any person addicted to narcotics who hires or uses a minor under 18 years of age to distribute narcotics is guilty of a high misdemeanor. *No Action*

A-165—To prohibit sale or purchase of firearms in certain cases; to prescribe standards for registration, obtaining permits, and for hearings upon denial thereof. *Disapproved,* because it would be practically impossible to carry out the provisions of the law.

*A-170—To provide that assistance to the blind shall not be granted to those in need of prolonged care in an institution because of a physical or mental condition unless the institution is a medical one; is not one to which funds are permitted to be made by municipalities; and the person is not a tuberculosis or psychosis patient. *Approved*

A-173—To prohibit commitment of sex offenders to mental institutions other than those providing entirely separate facilities. *Approved*

*A-183—To regulate and license the collection and disposal of solid waste; to create a Division of Refuse Control in the State Department of Health and an advisory council to said division. *Disapproved,* in support of the position of the Health Department that this legislation is unnecessary and undesirable.

A-197—To include the crimes of "incest" and "private lewdness" within the category of those offenses which require examination of the individual at the Diagnostic Center. *Approved*

A-216—To further define the phrase "glue containing a solvent having the property of releasing toxic vapors or fumes." *No Action*

*A-223—To increase the examination and license fees in the Nursing Act. *Approved*

A-251—To cover podiatrists' services under workmen's compensation health accident, disability, sickness, or other insurance; or under any labor-management trustee or union welfare plans or any private insurance or welfare plan. *No Action* .

A-255—To provide immunity from civil damage suits to volunteer first aid or rescue squad workers who are not members of a volunteer fire company. *Approved*

A-280—To require establishment and maintenance for a system of fingerprint identification of patients in institutions treating mental diseases. *Approved*

*A-287—To require every motor vehicle manufactured after July 1, 1967 to be equipped with a signalling system. *Approved*

*A-300—To transfer certain approval powers over hospital service corporations from the Commissioner of Institutions and Agencies to the Commissioner of Banking and Insurance. *No Action*

A-312—To permit recovery of hospital, medical, and funeral expenses incurred for one wrongfully killed. *No Action*

A-313—To amend the Workmen's Compensation Act to allow a claimant in a death action to file a claim petition within one year after the death of the employee, notwithstanding that such period of one year extended beyond the period of the present limitation. *No Action*

A-316—To authorize a municipality to contract to provide health services to any non-profit school. *Approved*

*A-317—To extend the time for filing petitions under the Workmen's Compensation Act in cases of exposure to ionizing radiation. *Approved*

*A-350—To require the county prosecutor to immediately initiate an investigation upon receipt of a complaint of physical abuse of children and to require report of the investigation to the Bureau of Children's Services. *Approved*

*A-397—To create "The Motor Vehicle Pollution Control Act (1966)" to control the emission of pollutants from motor vehicles; to establish a Motor Vehicle Pollution Control Board in the Department of Health and to provide for administration. *Disapproved*, as unnecessary, because it is a duplication of facilities provided for in S-25.

OBITUARIES

Dr. E. Clarence Kern

Dr. E. Clarence Kern, a prominent Essex County otolaryngologist, died on April 19 as a result of complications of surgery which had been performed in Cairo, Egypt, in March. Dr. and Mrs. Kern were on a trip around the world and on the way back when the Doctor developed a pancreatitis while in Europe.

Dr. Kern was born in 1896 and received his M.D. from Hahnemann in 1920. He did his residency at Manhattan Eye and Ear Hospital in New York City and graduate work in Europe, in Australia and Germany. During World War I, he served in the medical corps of our Army. On being mustered out, he returned to his native Montclair and resumed his practice. He became Director of the Department of Otolaryngology at Mountainside Hospital and served for two years as president of that hospital's staff. He was a Diplomate of the American Board of Otolaryngology.

Dr. Kern was a nationally-known figure skater and was president of the New Jersey Council on Figure Skating at the time of his death. He also was active in yachting circles and was prominent in various civic activities in West Essex.

Dr. James F. Lynch

On April 30, at the untimely age of 57, Dr. James F. Lynch died at his home. A native of Jersey City, he received his M.D. from Georgetown in 1933. He became Asistant Medical Examiner for Hudson County and was active in Hudson County medical and civic affairs. Dr. Lynch was associated with all the hospitals in Jersey City and served during World War II as a medical officer of the Army of the United States.

Dr. Ulysses S. Wiggins

South Jersey lost one of its most useful citizens on April 8, 1966 with the death that day of Ulysses S. Wiggins. A 1924 graduate of the medical school of the University of Michigan, Dr. Wiggins was, for a quarter of a century, president of the Camden County branch of the NAACP. He also had had long tenure on the national board of the NAACP. He came to Camden County, from his native Georgia, in 1928 and has been serving the people of southern New Jersey since then. He was a city physician, a school examiner, and surgeon to his adopted city's highway department. Dr. Wiggins was affiliated with the Cooper Hospital as a senior attending. He was 69 years old at the time of his death.

BICENTENNALIA

Henry L. Coit: Pediatrician And Sanitarian

Dr. Henry L. Coit was selected by the journal, *Postgraduate Medicine* (29:556, May 1961), as the New Jersey representative for its "Great Names in American Medical History" — a series of biographic sketches of outstanding physicians of the past from each of the fifty states. Citing Coit as "among the unsung names in the history of medicine," the journal reviewed his remarkable career and international stature. Today the Coit Memorial Hospital of Newark and the Henry L. Coit Building at the State Colony at Woodbine memorialize him in his own state. Even more enduring, however, are the countless cases of sickness and death averted through his groundbreaking work in pediatrics, public health, and milk sanitation.

Henry Leber Coit was born at Peapack, N.J., on March 16, 1854. He was the son of a Methodist minister who died when the boy was twelve years old. While earning his schooling, he worked in a drugstore in Newark, sleeping under the counter at night. Graduated from the New York College of Pharmacy in 1876, he taught there while attending medical school. Receiving his M.D. degree from the Columbia University College of Physicians and Surgeons in 1883, he served an internship in Newark and became a general practitioner.

Dr. Coit married Emma Gwinnell of Newark in 1886. It was the unforgettable death of their first son, during a diphtheria epidemic, that began Coit's inspired crusade to improve the health of all infants and children.

Seeking pure milk for his dying son, the Doctor observed filthy conditions at some of the local farms, where milk was dipped by hand from forty-quart cans. This prompted him to make a study of the milk supply. He next tried to obtain legislation for the control of milk supplies, but was unsuccessful. He then read a paper in 1892, before the Practitioners' Club of Newark. In it he presented his plan for chemical, bacteriologic, and veterinary standards of milk production. He advocated that dairy hygiene and the health of dairy employees be supervised by physicians. From these initial proposals came the phrase, "certified milk."

Coincident with the establishment of the Essex County Medical Milk Commission in 1893, with Coit as its president, a leading dairy farm in Caldwell accepted the challenge to produce this highest quality milk. From the famous Fairfield Dairy of Mr. Stephen Francisco, a dairyman devoted to the cause of wholesome milk, came the first bottle of certified milk. This was also the first time that commercial milk was dispensed in individual bottles. The first bottle, tied with a blue ribbon, was delivered to Mrs. Coit — whose encouragement and loyalty had contributed so much to her husband's success. Mrs. Coit in turn gave the milk to her two year-old daughter. Dr. Coit travelled to Europe four times to participate in related international congresses. At his death on March 12, 1917, sixty Medical Milk Commissions were functioning in the United States and Canada, with several others in Europe and Asia.

The Babies' Hospital of Newark, founded in 1896 by Dr. Coit, was later named in his honor. From humble beginnings in a converted house came the well-equipped hospital of today. Along with the original Babies' Hospital, several "Baby Keep Well Stations" were opened in different parts of Newark to supplement a central clinic established for that purpose.

In 1916, during a severe epidemic of poliomyelitis, Coit, then sixty-two years old, organized the Citizens' Relief Committee which provided funds for physical therapists and specially trained nurses for poliomyelitis patients. A medical propagandist, his more than twenty-five published articles illustrated a wide range of professional interests. He served for several years as collaborating editor of the *Archives of Pediatrics.*

On the death of Dr. Coit, his colleague, Dr. Elmer G. Wherry, later director of the Coit Memorial Hospital, told the Newark Practitioners' Club: "His memory is an inspiration. His good deeds are an example. His humanitarian and altruistic spirit . . . a perpetual heritage."

Fred B. Rogers, M.D.

An Editorial Of 50 Years Ago

The following appeared in the June 1916 issue of this Journal.

The approaching 150th anniversary of our Medical Society in 1766 causes one to look back into the mazes and shadows of our colonial history. It awakens a flush of pride that ours should have been the first in all America to co-ordinate medical thought and aspiration.

In the other colonies there were gifted minds and responsive hearts, but, except at the frequent consultations held at the bedsides of stricken patients, there were no conventions of ideas, no shifting of evidences, and shaping of opinions, no benevolent regulation of conduct, none of the bonhomie and candour that comes with fellowship in a community of common interests.

But all of this began at New Brunswick, that historic town, in 1766, when sixteen physicians formed themselves into the New Jersey Medical Society. With admiration we read their "Instruments of Association and Constitutions" — what zeal, what dignity, what benevolence! And though they were all comparatively young men, and mostly college bred, and destined to cut a great figure in the approaching Revolution, and in the councils of the government, we cannot help but look upon them as old men, the fathers of medicine in the primitive days — the sages of an antique era!

We fancy them on their daily rounds of 20, 30, 40, even 50 miles of travel — stately equestrian figures, in quaint habiliments, calling at rude log cabins under the forest eaves; and view their hospitable receptions at the ampler homes of the rich planters. We follow their lonely journeys by Indian trails, their fording of streams and perilous crossing of swirling rivers, and come upon their surgery in some sudden calamity, at night, in some remote dwelling, performed by the doubtful light of candles, or of smoky lamps. These were the men that kept the torch alive in perilous times: they assuaged diseases, comforted despairs, inspired patriots, bore the brunt of battles, and were the last to leave the fields of carnage.

And through it all, their tendency was toward ampler horizons of thought. In no other profession is there a keener desire to improve upon old accepted forms and methods. For below the surface of earnest minds, an evolution of ideals is ever glimmering. The realizations of to-day were the theories and surmizes of unremembered men. Nothing flowers that has not had its roots in the debris of old dreams.

We shall meet to do them honor, and it were nothing strange if amid the feasting and the flow of soul, the garlands, the music, the oratory, and applause, something more subtle than memories should drift in, and smile a grace of welcome, and inspire us yet to nobler living and a higher art!

George T. Welch, M.D. 1916

BOOK REVIEWS

The Excitement and Fascination of Science. Various authors. Published 1965 by Annual Reviews, Inc. Palo Alto, California. Pp. 565. ($1.95 in soft-back and $5 in hardback)

Our increasing concern with the humanities, the behavior sciences, and the social sciences has, perhaps, led to de-emphasis on the more traditional sciences. In helping maintain excellence in the natural sciences, a prime position goes to the *Annual Reviews* which cover chemistry, physiology, pharmacology, and so on. For many years, each volume has had a preface or introduction. Now in this unique work, the editors have assembled a collection of the best of these prefatory essays. Here one finds such whimsical gems as George Bishop's "Life among the Axones;" as Albert Szent Gyorgi's charming, yet biting, "Lost in the 20th Century;" as Wallace Fenn's thought-provoking essay "Born Fifty Years Too Soon." Linus Pauling contributes a solid and nostalgic historical work on fifty years of the California Institute of Technology.

Many of these essays are hard reading, because they assume a high degree of literacy and sophistication in the reader. But to the man or woman who can meet that expectation, this is an enchanting work — at once serious and humorous, fact-filled, and witty — a veritable jewel box of ideas. VICTOR HUBERMAN, M.D.

Diagnosis and Therapy of the Glaucomas. B. Becker, M.D. and R. N. Shaffer, M.D. Ed. 2, St. Louis, 1965, Mosby. Pp. 442 with 288 illustrations. ($18.50)

The first edition was recognized as an outstanding and indispensable book for the ophthalmic clinician and resident physician in ophthalmology. The organization of the pathogenesis, diagnosis, and management of the glaucomas in one easily understood and well-illustrated volume has given all of us an opportunity to update our concepts of this complex disease. New information has accumulated to an extent requiring a complete rewriting of major portions of the text just four years after the first edition. Surprisingly, this has been true for basic aspects of ocular anatomy and physiology as well as clinical applications.

With the aid of the electron microscope, photographs and diagrams unfold some of the mystery surrounding the aqueous flow through the drainage mechanism. The authors have brought us to the brink of understanding the pathogenesis of open angle glaucoma.

The chapter on gonioscopy has been expanded and further supplemented with a chapter of gonioscopic examples. Each example is illustrated with a full page sketch accompanied on the adjoining page by an actual case history. Tonography is treated in a similar way with illustrations of tonograms accompanied by a case history. The tonograms often show the effect of medication on outflow facility with four or five tracings over a period of time.

Medical technics in the last few years have improved, and appreciably add to our skill in handling acute glaucomatous cases, especially in preparation for surgical intervention. HOWARD M. EISENSTODT, M.D.

Cardiac Evaluation in Normal Infants. R. F. Ziegler, M.D. St. Louis, 1965, Mosby. Pp. 170 with 29 illustrations. ($12.75)

This is a monumental and magnificent volume. Within its covers is compressed an unbelievably complete and thorough coverage of the entire subject of infant cardiology. In a mere 140 pages of actual text, Dr. Ziegler has managed an exhaustive discussion and detailing of every significant factor and manifestation relating to the heart of the infant. If the reader of these words gathers that I am enthusiastic about this book, that is not the half of it; I am breathless with excitement!

The title of the volume is misleading. Dr. Ziegler systematically discusses, chapter by chapter, fetal and neonatal circulation, normal neonatal and infant cardiac physiology, murmurs and their evaluation, cyanosis, rate and rhythm, heart size, heart failure, abnormalities of function due to cardiac and to non-cardiac abnormalities, and related matters. While his basic approach is to stress the variations of the normal and the passing abnormalities, he obviously clarifies the abnormal as well. The use of the word "normal" in the title should lead no one to believe that this is not a valuable contribution to the cardiac evaluation of *all* infants. The use of well selected and excellently reproduced electrocardiograms adds much to the text. The bibliography is exhaustive and will be made use of by many who wish to go into finer points of one or another subject.

It does not seem to me that a second edition of this book should be needed for a long time, so highly do I regard the present publication. But should one ever be contemplated, I would hope for a correction of the only criticism I can make: that is the constant use of parenthetical phrases meant to clarify or explain but serving to interrupt the reader's train of thought and frequently to confuse him instead of aiding his comprehension.

This volume, I think, should be not in the library but on the desk of every pediatrician, cardiologist, and anyone else having to do with the care of the newborn and young infant. CLEMENT E. SCHOTLAND, M.D.

Operative Obstetrics. R. Gordon Douglas, M.D. and William B. Stromme. Edition 2. New York, 1965, Appleton-Century-Crofts. Pp. 779. ($22.50)

Up-to-date treatment of all aspects of operative obstetrics is presented in this new edition. Unlike some books on this subject, this is neither simplified nor expanded to tedious detail. The more vital subjects receive space proportionate to their importance. Procedures and concepts not applicable to modern obstetrical management have been discarded. Detailed descriptions of important new procedures (such as the Shirodkar operation) and diagnostic amniocentesis and intrauterine transfusion are provided. The illustrations are clear and plentiful. Basic operative obstetrical procedures remain well covered. This book could serve as a primary text at all levels of training.

While the authors draw most of their statistics from one large institution, they beat no drums and are fair in presenting and illustrating controversial viewpoints of management. Frequent comparative statistics in different recent obstetrical eras give the reader a rare opportunity for good perspective. This is a valuable and readable reference source and refresher text.

J. B. SKELTON, M.D.

Man and Africa. Edited by Gordon Wolstenholme and Maeve O'Connor. Boston, 1965, Little, Brown and Company. Pp. 400, 24 illustrations. ($7.50)

In October 1964, Emperor Haile Selassie authorized the Ciba Foundation to set up an international conference on the present, the potentialities, and the projected future of Africa. Here is transcript of that session, held in Addis Ababa. Sixteen different papers are presented by as many different authorities. The spectrum is enormous: telecommunications in Africa, economic development, meteorology, investment opportunities, food and water resources, perspectives for industrialization, educational needs and opportunities, language problems, sociologic aspects, health, transportation, and the varying cultural impacts of the different tribes. The papers are short and compact, the tables are illuminating, and the maps are instructive. The topic is, of course, somewhat specialized. But for anyone interested in human behavior and sensitive to the enormous problems of the awakening giant we call Africa, this book is a superb basic volume.

ULYSSES FRANK, M.D.

Injuries of Nerves. S. Weir Mitchell, M.D. New York, 1965, Dover (Reprint of an 1872 Lippincott publication). Pp. 377. Paperback. ($2.75)

Perhaps one of the most versatile Americans after Thomas Jefferson was Doctor Silas Weir Mitchell. Interestingly enough, he was a graduate of the Jefferson Medical College. He was a writer, a neurologist, a military surgeon, a toxicologist, an administrator, a historian, and a man for all seasons. Of Weir Mitchell, Osler said: "We have to go to other centuries to find a parallel in his career."

His 1872 work on the history of nerves is here reprinted, apparently, from the original plates. This entire work is an elaboration of what was known up to date on that subject, and it laid the foundations for much of later knowledge in the physiology of the peripheral nervous system. This book was the most monumental study of neurophysiology in the nineteenth century. It was used as an authoritative reference work for many decades after its publication, and practically all knowledge of the distribution and functioning of our peripheral nerves owes something to this remarkable work. To the practicing clinician, the text would be of only limited value. To anyone who is proud to be called a "doctor" in the fullest meaning of that noun, this is a volume he would be pleased to own and browse through.

HENRY A. DAVIDSON, M.D.

Handbook of Physical Medicine and Rehabilitation. Edited by Frank H. Krusen, M.D. Philadelphia, 1965, W. B. Saunders Company. Pp. 725, illustrated. ($16.50)

This latest addition to the literature of physical medicine is an attempt to show how the patient can reach maximum potential for control of his handicap or disability. It is directed at psychological, social, vocational, and physical adjustment. The text covers 25 chapters, written by as many specialists. The book shows a tendency to be rather non-specific in certain areas because of the effort to cover too many subjects in too thorough a presentation in many areas.

For example, it presents in depth technics of physical management — ranging from therapeutic heat, ultraviolet therapy, iontophoresis, and exercise. Another section is devoted to wheelchairs, assistive devices, prosthesis, and bracing. A third section deals with management (from a rehabilitation standpoint), of specific disorders — including hemiplegia, connective tissue lesions of the spinal cord, fractures, lower motor neuron disorders, peripheral nervous system disorders, back disorders, and so forth. Another area concerns itself with diagnostic procedures and includes electromyography and peripheral vascular evaluation.

It is well-written and has over 300 helpful drawings and photographs, which illustrate the procedures in the devices described. A chapter on preparation of a properly written prescription for physical and occupational therapy will be helpful to the practicing physician.

This book has real value for orientation to the field, but it is felt that a disassociation of physical medicine procedures and evaluation of rehabilitation technic could not be covered thoroughly in a book of this type. It should be handled separately in two different publications.

EARL F. HOERNER, M.D.

Fundamentals of Clinical Hematology. Edited by Byrd S. Leavell, M.D. and Oscar A. Thorup, Jr., M.D. Ed. 2. Philadelphia and London, 1966, Saunders. Pp. 597, illustrated. ($12.50)

This revised edition of a recently published text continues to fill the need for a concise presentation of the clinical and laboratory findings in hematology. Among its outstanding features are the frequent pertinent case summaries illustrative of the areas under discussion and the section at the end of the book devoted to a presentation of numerous technical procedures with indicated direct references to the literature.

Worthy of particular attention are the sections on blood coagulation and that on the plasma protein changes in proliferative disorders of plasma cells and lymphocytes. While neither problem is presented exhaustively, nevertheless there is an excellent summary of up-to-date concepts.

This text is in no way an atlas of hematology. Indeed, its lone colored photograph is only a re-issue of a previous print.

LESTER M. GOLDMAN, M.D.

Current Pediatric Therapy 1966-67. Sidney S. Gellis, M.D. and Benjamin M. Kagan, M.D. Philadelphia, 1966, Saunders. Pp. 956 ($17.50)

This second edition follows the authors' desire to "bring up to date the advances in therapy which have taken place in the past two years." Almost half of the previous contributors have been replaced and many new subjects added such as: psychopharmacologic agents, skin care, infection with the unclassified mycrobacteria, sting insect hypersensitivity, and a useful "roster of drugs." This lists the form and description of the various drugs mentioned in the text. To single out one section for comment, the chapter on antibiotics with the discussion of management of specific infections is outstanding. In fact, I would recommend this chapter to some of the contributors for careful study. Too many of them show a rather casual attitude towards antibiotics. For example, one would question the use of chloramphenicol for such conditions as prophylaxis in possible exchange transfusions, in hemolytic staphylococcus aureous infections associated with burns, and for dermal sinus infection. In the latter instance, the dose recommended is rather high. This highly practical book should be useful for any physician dealing with children.

WILLIAM H. FOST, M.D.

Animal Behavior and Drug Action. Ciba Foundation Symposium. H. Steinberg, Ph.D., A. V. S. de Reuck, M.Sc. and J. Knight, B.A., Editors. Little, Brown and Company, Boston, 1964. Pp. 491, illustrated. ($13.00)

Psychopharmacology (use of drugs in the treatment of mental illness) is one of the newest and most rapidly expanding branches of therapeutics. The principle theme of this book is the prediction of drug-induced behavioral effects from animals to man. This can be done if the behavioral pharmacologist can set up in his laboratory a carefully selected individual animal for each type of patient seen by the clinical psychiatrist and if he can study the effects of drugs on this animal model. The perplexities involved in setting up such a test situation are here discussed by prominent psychopharmacologists and by experimentalists from other disciplines, such as biochemistry, genetics, and neurology.

Although this book furnishes an excellent summary of the current problems in behavioral pharmacology, it does not supply the reader with any stimulating new ideas. As an introduction to this new area of pharmacology, it is highly recommended to psychiatrists, psychologists, pharmacologists, and pediatricians.

HAROLD M. BATES, PH.D.

Neuro-Ophthalmology. Edited by J. Lawton Smith, M.D. St. Louis, 1965, C. V. Mosby. Pp. 276. Second Volume. ($21.75)

Here is a handsome, well-printed, and beautifully-illustrated book, reporting the discussions held at a symposium sponsored by the University of Miami School of Medicine in January 1965. The material presented is uniformly timely and interesting.

This is in no sense a textbook, but rather a collection of research and clinical studies by outstanding men in their fields. Of special value are the sections on heredodegenerations of the retina, in which the underlying mechanism of "strokes," the neuropathology, and the diagnostic features are all well shown; a chapter on the orbicularis oculi, which is interesting in its detail and in the practical significance of the varied signs and symptoms.

The new technic and application of fluorescein injection in studying the fundus oculi is stimulating when considered as another diagnostic aid that may well be of increasing value. The illustrative photographs here are outstanding.

To those particularly interested in neuro-ophthalmology, this book is of unquestionable value. To others, let them study carefully the table of contents before buying.

S. JEROME GREENFIELD, M.D.

Ferment in Medicine. By Richard M. Magraw, M.D. Philadelphia, 1965, W. B. Saunders Company. Pp. 272. ($6.50)

This unusual volume concerns itself with all factors of the medical world, as they are alone, as the current changes are making them, and as they are when combined. Dr. Magraw suggests that these present changes are not clearly recognized by all of us. Yet we most recognize these changes to keep pace with the progress which exists today. This book touches upon almost every aspect of medical care and practice. Presented individually, step by step, are the roles of the patient and the doctor, and the types of relationships and "contracts" which bind the two.

The effect of these changes in medical institutions is also discussed: alone, as in relationship to the patient and in the different relationships of the physician to the hopsital; his patients in the hospital, and between him and the hospital personnel and administration. We are shown how these relations used to be, are at present, and might be expected to be in the future. A brief history of the hospital is included.

The author touches upon the effects of specialization in medicine. He discusses the problem of coordination and the integration of these specialized parts which must come together to make up the medical field. Some opinions on how this integration can be carried on by doctors are voiced. Also reviewed are the financial phases of the doctor-patient relationship. We are told about prepayment and health insurance.

The uses made of automation, and the effects of this on medical practice and research are discussed.

This book deals with the *changing times* in medicine, a force which too few of us realize. Let all those now in practice, and those who are entering the profession, become acquainted with this book!

LOUIS F. RAYMOND, M.D.

Surgery in World War II . . . Thoracic Surgery. Volume II. Edited by Frank B. Berry, M.D. Washington, D. C., 1965, Department of the Army. Pp. 615, illustrated. ($7.25)

Publication of this volume on thoracic surgery in World War II, by reason of the need for a second volume, shows the extent of the material encountered and instead of being a tactic statistical report of the occurrence of thoracic lesions in the second World War, might well serve as a text book in thoracic surgery, since in its completeness it covers the field in detail in brilliant fashion and because of this may well become a standard reference book.

This volume is done in 615 pages with 222 illustrations, 3 colored plates, 4 tables and a comprehensive index and is available at $7.25 a copy from the Superintendant of Documents, Government Printing Office, Washington, D.C. 20402.

The text is divided in three parts, part one being confined to special types of wounds of the chest and thoracoabdominal wounds. This is edited by Lyman A. Brewer III, M.D. and Thomas H. Burford, M.D.

The second part covers complication of wounds in the chest and introduces the clinical edity, Wet Lung, its concept, general considerations pathology and treatment as the initial appearance of this condition as a clinical edity. Its recognition and successful treatment undoubtedly saved thousands of lives and returned most of its suffers to useful lives. This section was also edited by Thomas H. Burford M.D. and Lyman A. Brewer, III, M.D. together with Dwight E. Harken, M.D. who was responsible for the chapter on Management of Retained Foreign Bodies in the heart and great vessels. (European Theatres of Operation.)

The third part on observations on wounds and diseases of the chest, in the Zone of the Interior, was edited by Brian B. Blades, M.D., B. Nolan Carter, M.D. and Michael E. DeBakey, M.D. It is a masterpiece of medical writing and completely covers a wide range of observation in this area.

DANIEL F. FEATHERSTON, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

JUNE, 1966 • VOL. XXXIX, NO. 6

In a review of reports of 109 tuberculosis epidemics in 12 countries, adults were found to be the usual source of infection. None of the epidemics was caused by children with primary tuberculosis. Identification of the source case is essential to control of the epidemic.

EPIDEMICS OF TUBERCULOSIS

A review of 109 epidemics of tuberculosis in 12 countries, 84 (75%) of which were in schools, permits of certain generalizations about tuberculosis epidemics.

Any outbreak of tuberculosis results from a combination of circumstances. First, a large proportion of the group of individuals exposed to tuberculosis must be tuberculin negative. This state is usually associated with a lack of acquired immunity and is seen particularly in young children or in older individuals living in geographic areas where the tuberculosis rate is very low. The second factor is the presence of an individual who is a disseminator of tubercle bacilli, almost invariably an adolescent or adult with pulmonary tuberculosis.

The sputum of the disseminator usually contains many tubercle bacilli which can be detected on direct examination. Culture of the sputum yields a high colony count. In patients from whom the bacilli can be recovered only by culture, there are usually fewer colonies. Such patients are less likely to be contagious and are therefore harder to identify as the source of epidemics.

However, all patients with large numbers of living tubercle bacilli in their expectorations may not be of the same degree of contagiousness. It has been reported that the number of bacilli a patient discharges into the atmosphere depends not only on the number of bacilli in his sputum, but also on the fluidity of the sputum, the frequency and forcefulness of coughing and sneezing, and such factors as whether or not the patient covers his mouth when coughing.

An example of this was the rapid spread of tuberculosis in a military band in Great Britain. A 23-year-old clarinet player was found to have infected eight other persons connected with the band who developed active pulmonary tuberculosis.

Members of bands appear to exhale more air than the average person and with much greater force, probably keeping droplets airborne for a longer time, and producing a greater concentration of airborne bacilli.

Adults Are Source of Infection

Most epidemics are traceable to adults with contagious tuberculosis. In schools the sources are usually teachers, but may be a bus driver or custodian, a cook or some other person who comes in close, even if brief, contact with the pupils. Many school epidemics also have been ascribed to older children or to adolescents with chronic pulmonary tuberculosis.

The potential contagiousness of children with primary tuberculosis has been questioned for many years. A child with recent pulmonary primary tuberculosis may be assumed to have a few tubercle bacilli in a gastric lavage. The question is whether this means that the child is contagious. Children with nonprogressive

EDITH M. LINCOLN, M.D. *Advances in Tuberculosis Research;* Karger, Basel/New York, 1965.

pulmonary tuberculosis rarely cough, and they do not expectorate. Therefore, they probably do not disseminate tubercle bacilli into the atmosphere. Many pediatricians have seen children with nontuberculous pulmonary disease spend months or years in hospitals with tuberculous children and not develop a reaction to tuberculin. In the present review there was not a single report of a school epidemic caused by a child with primary tuberculosis.

Another important factor in the production of epidemics is the environment in which the contact occurs. Overcrowding and lack of ventilation increase the chances of infection.

Spotting the Epidemic

The early recognition of an outbreak of tuberculosis depends on how quickly the physician or health authority thinks of tuberculosis when a number of people in a small area have fever of unknown origin. Once tuberculin tests and subsequent chest X-rays are positive, the presence of an epidemic becomes obvious.

Multiple cases of erythema nodosum have been of help in arousing suspicion. Although relatively rare today, erythema nodosum is still a valuable guide to an epidemic of tuberculosis. Often epidemics are suspected as a result of finding a sudden increase in the number of tuberculin reactors in a community.

Most recognized epidemics develop in an incredibly short time. In one Norwegian village, an itinerant juggler caused 54 infections within a month. In such instances, it is clear that the exposed population has little or no acquired immunity and that the individual who is the source of infection has numerous bacilli in his sputum.

The first concern of the physician faced with an epidemic of tuberculosis should be to identify the source case. In schools this should not be difficult if all the personnel and older students are surveyed by tuberculin tests and by chest X-rays of all reactors. If the source is not found, the search must be continued outside the immediate classroom.

An adult or adolescent with active chronic pulmonary tuberculosis should be sent to a hospital or sanatorium for adequate therapy. An adolescent with pulmonary tuberculosis should not return to school until his disease is stabilized and cultures of sputum have been negative for three to six months.

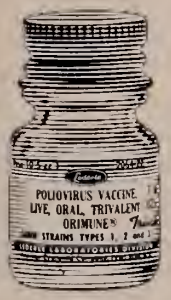
Caring For the Child

A child with symptomatic primary tuberculosis should be treated at home or in a sanatorium according to his medical needs and the ability of his family to give him adequate care at home. Students with asymptomatic primary tuberculosis should be allowed to stay in school provided they remain under medical supervision and take isoniazid daily for at least a year. The addition of PAS is a matter of opinion. Isoniazid is given primarily to prevent complications since no drug therapy is known to eliminate all tubercle bacilli from the body. Thus, following an epidemic all tuberculin reactors should have chest X-rays at yearly intervals for an indefinite period. Home contacts should also be examined.

The tuberculin test is the most valuable tool for tuberculosis control. It permits the classification of those who are uninfected and hence susceptible to infection and those who have been previously infected with tubercle bacilli. As the rate of infection decreases, tuberculin surveys, with chest X-rays only of reactors, may become the method of case finding in adults as well as in children. It is essential to follow all the individuals known to react to tuberculin, particularly in countries with a low incidence of tuberculosis. Only in this way can pulmonary tuberculosis be found early, when it is most amenable to treatment.

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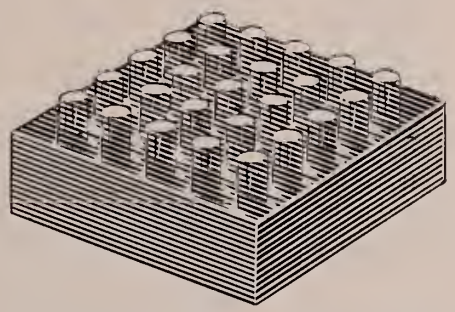


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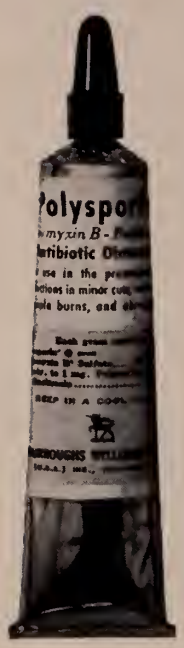
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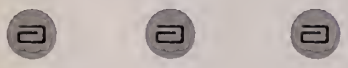
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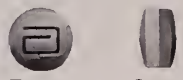
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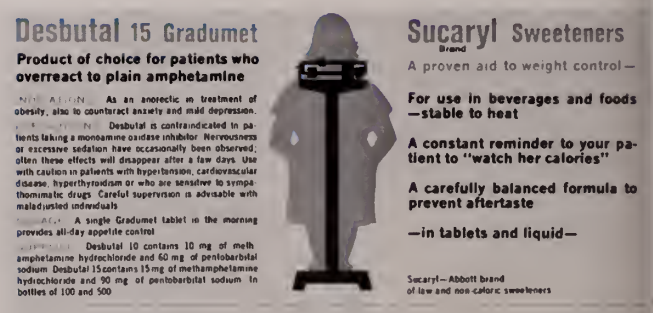


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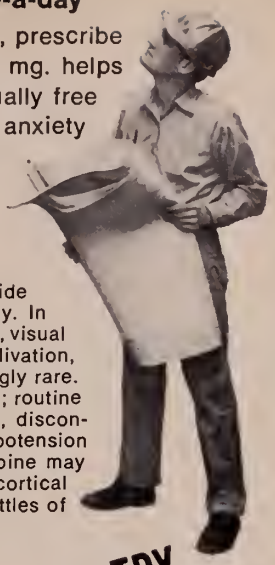
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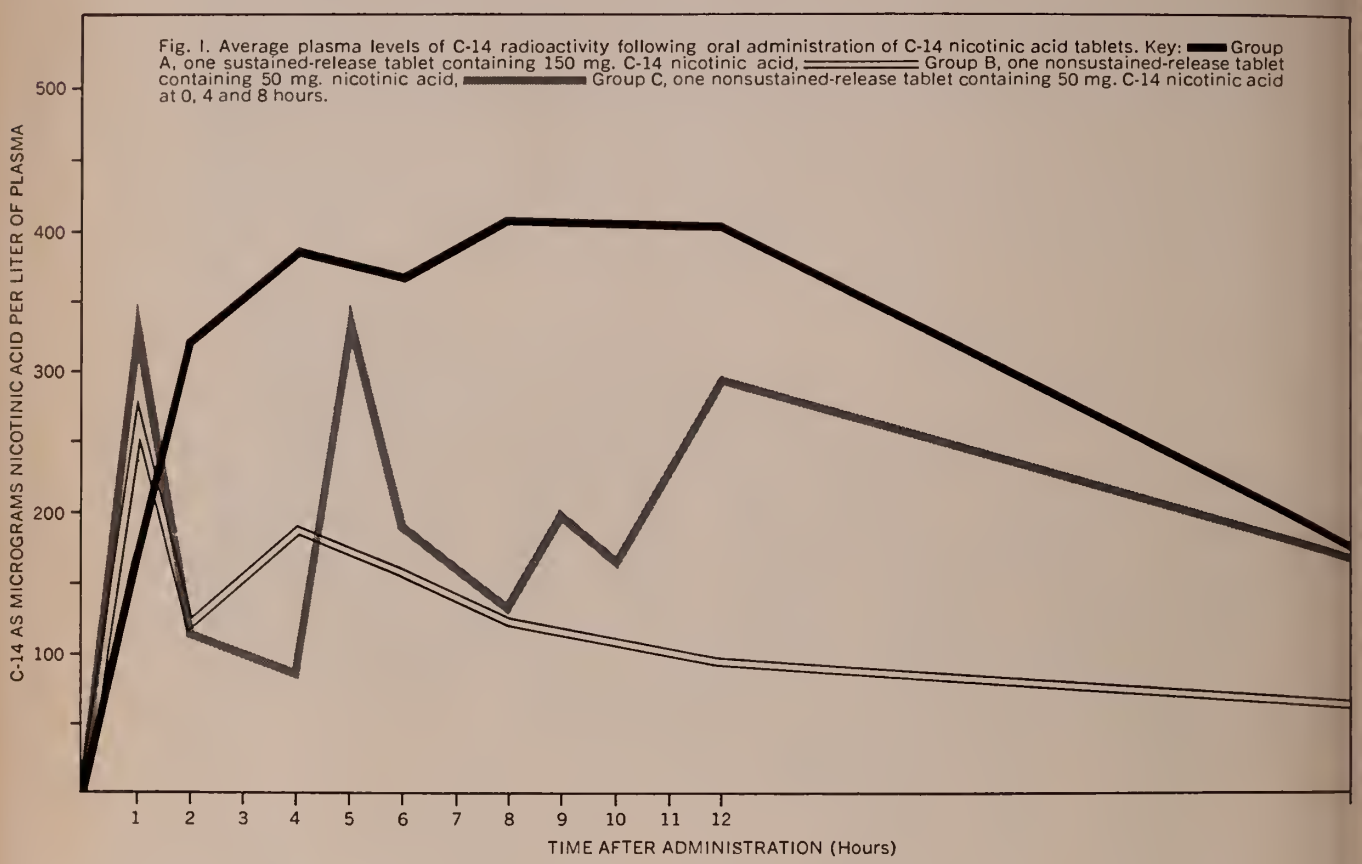


Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.



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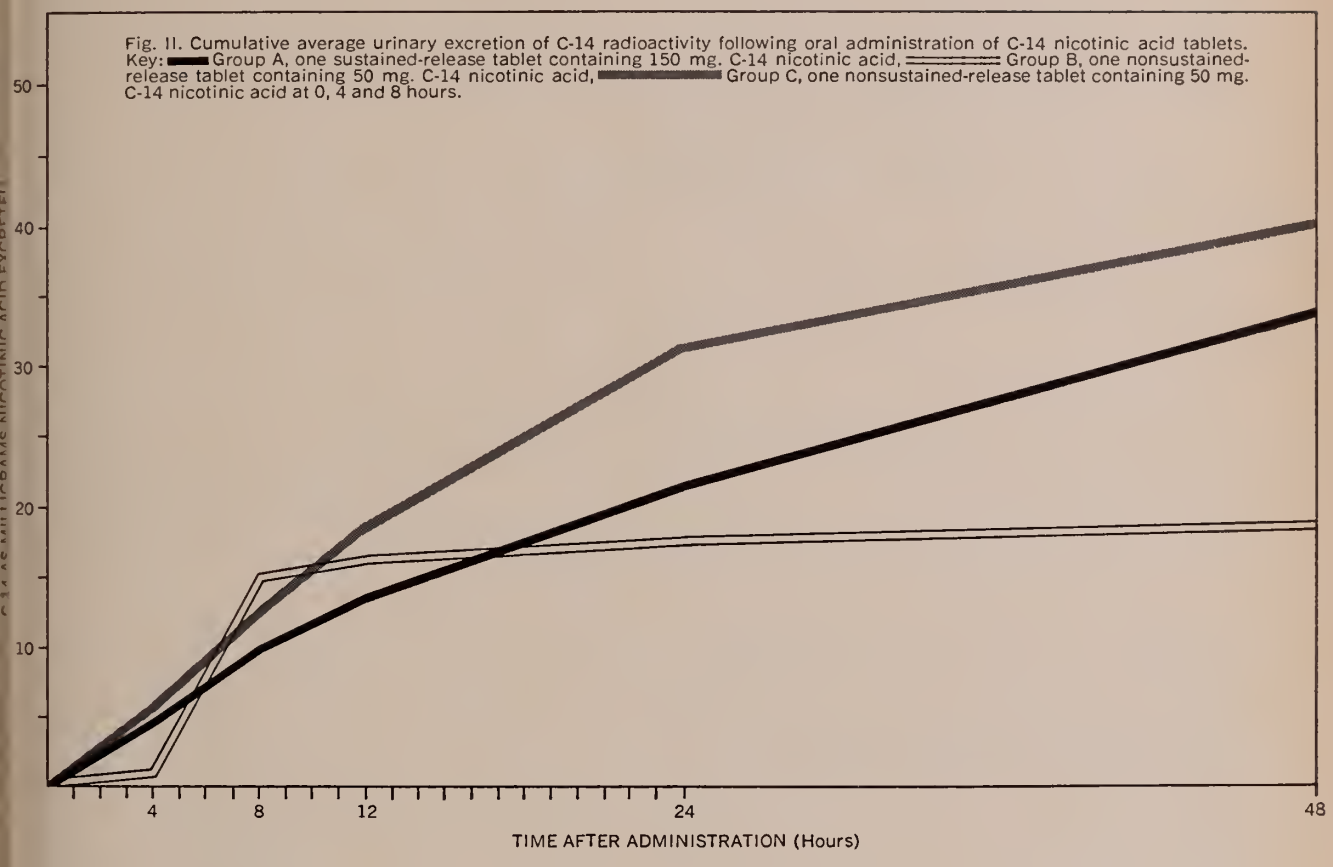


Fig. 11. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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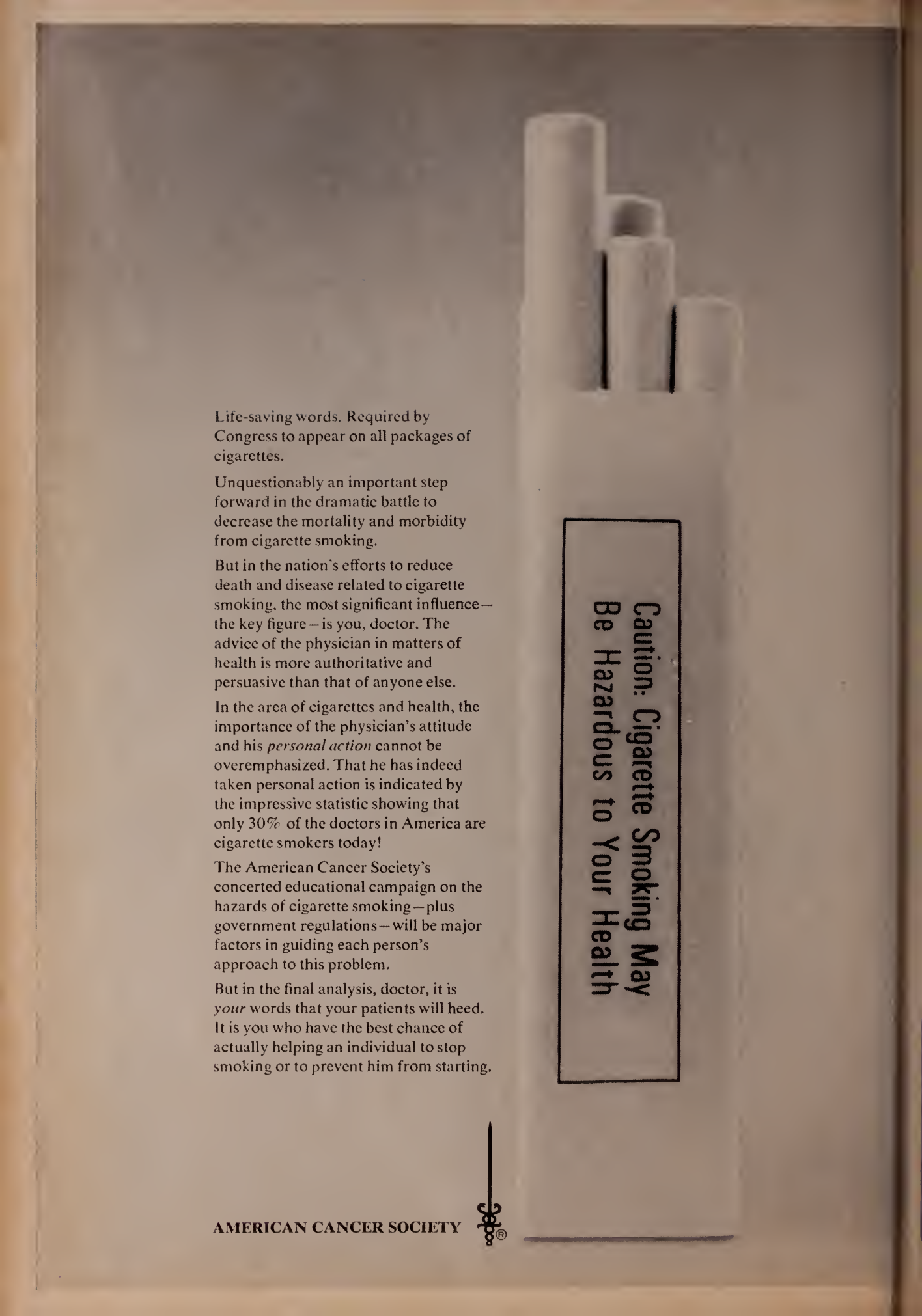
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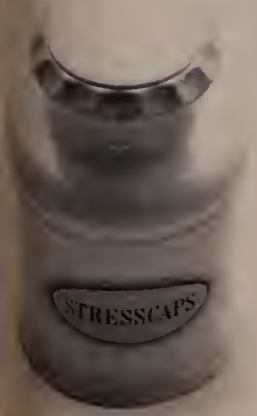
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1. Barowsky, H.; Greene, L., and Paulo, D.: Cinegastroscopic Observations on the Effect of Anticholinergic and Related Drugs on Gastric and Pyloric Motor Activity, Amer. J. Dig. Dis. *10*:506-513 (June) 1965.

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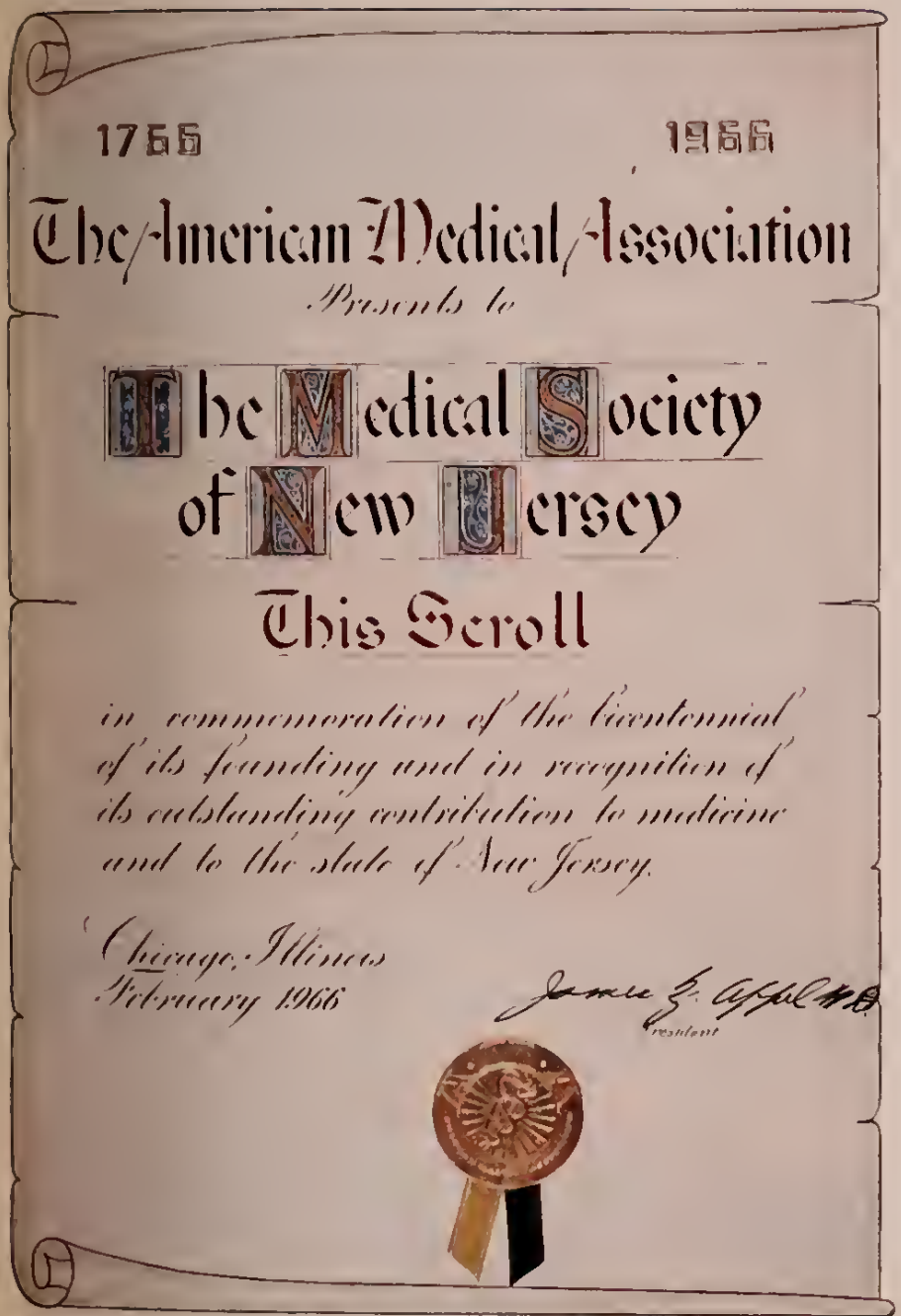
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CONTENTS • Pages 223 to 278

A Message from Lyndon B. Johnson 223

EDITORIALS
Our New President 224
Bicentennial Commemorative Issue 224
Good Character and Professional Fitness 225
Marion Glazier 225

BICENTENNIAL GENERAL ASSEMBLY
Address of Governor Richard J. Hughes 226
Address of Morris Fishbein, M.D. 228
Address of James Z. Appel, M.D. 237

PICTORIAL REVIEW 242

SYMPOSIUM ON GASTROINTESTINAL BLEEDING
Bleeding in Varices and Hiatal Hernia
William S. Blakemore, M.D.; Moreye Nusbaum, M.D.; and Arthur E. Baue, M.D. / Philadelphia, Pa. 256
The Medical Approach
Henry J. Tumen, M.D. / Philadelphia, Pa. 260

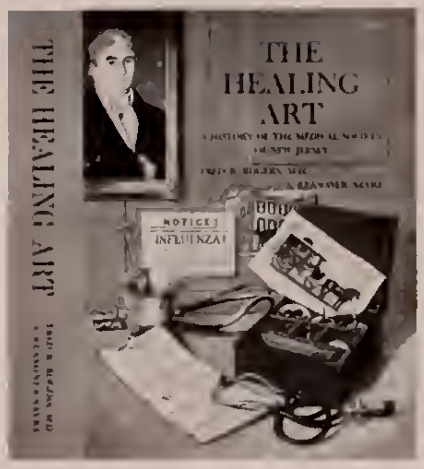
DINNER DANCE — 1966 266
Address of Mason Gross, Ph.D. 268

STATE ACTIVITIES
Chairmen of Councils/Committees 236
Bicentennial Souvenirs 241
Address of Retiring President 273
Golden Merit Award 274
The Healing Art 275
Legislature Congratulates MSNJ 278

BICENTENNALIA 276

JULY 1966 • Vol. 63, No. 7

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in diarrhea

LOMOTIL®

Tablets
Liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.



is a corker

Effectiveness: Lomotil possesses a unique degree of effectiveness in both acute and chronic diarrhea.

Convenience: Lomotil is supplied as small, easily carried, easily swallowed tablets and as a pleasant, fruit-flavored liquid.

Versatility: The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or as adjunctive therapy in diarrhea associated with:

- **Ulcerative colitis**
- **Acute infections**
- **Irritable bowel**
- **Regional enteritis**
- **Drug therapy**
- **Food Poisoning**
- **Functional hypermotility**
- **Malabsorption syndrome**
- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: 3 to 6 months — 3 mg. (½ tsp.* t.i.d.)
6 to 12 months — 4 mg. (½ tsp. q.i.d.)
1 to 2 years — 5 mg. (½ tsp. 5 times daily)
2 to 5 years — 6 mg. (1 tsp. t.i.d.)
5 to 8 years — 8 mg. (1 tsp. q.i.d.)
8 to 12 years —10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the therapeutic dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE *Research in the Service of Medicine*



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





when readings indicate hypertension

Time for Naturetin®

SQUIBB BENDROFLUMETHIAZIDE

to reduce blood pressure

In the management of your hypertensive patients, Naturetin is good therapy to start with, good therapy to stay with.

In mild hypertension, Naturetin lowers blood pressure gradually toward normotensive levels. In long-term therapy, Naturetin may keep blood pressure low—for months, sometimes years. When used in combination with other antihypertensive agents, blood pressure often falls further—and lower doses of both drugs are usually possible.

Clinical trials have proven Naturetin effective—without serious side effects.[1,2] And, when used to treat patients with cardiac edema and hypertension, "in no instance did the concentration of serum potassium fall below 3.1 mEq. per liter."[3] (Normal range for serum potassium: 3.5-5.0 mEq./liter).[4]

When readings indicate hypertension, start with Naturetin, stay with Naturetin.

Contraindications: Severe renal impairment; previous hypersensitivity.

Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

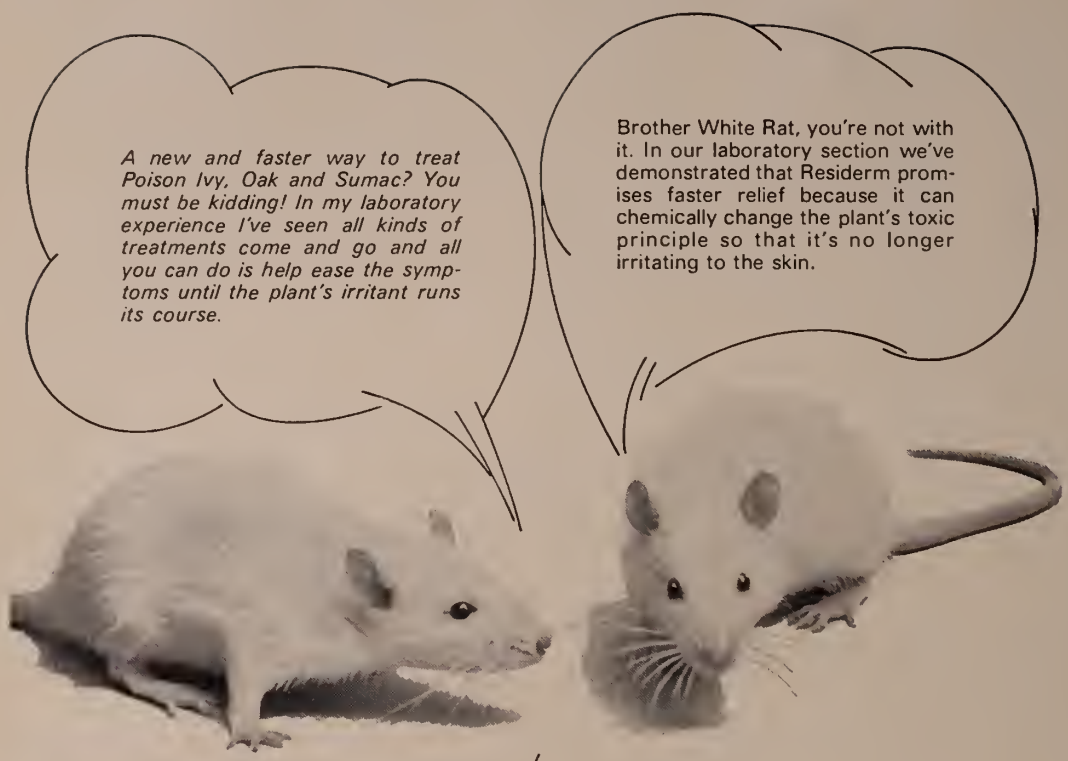
Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available—Naturetin c K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: 1. Telfeyan, S. A.: Clin. Med. *70*:1668, 1963. 2. Shepard, H. L.: J. Am. Geriatrics Soc. *11*:363, 1963. 3. Cummings, D. E.; Goodman, R. M., and Steigmann, F.: J. Am. Geriatrics Soc. *12*:161, 1964. 4. Castleman, B., ed.: New England J. Med. *268*:1462, 1963.

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RESIDERM®

POISON IVY LOTION

AIMS AT THE CAUSE INSTEAD OF THE EFFECT OF POISON IVY, OAK AND SUMAC

Detoxifies the toxic principle of Poison Ivy, Oak and Sumac and converts the irritant to an inactive, non-irritating bound complex through the mechanism of ion-exchange.

DESCRIPTION: Residerm lotion containing a quaternary amine-type anion exchange resin as its active ingredient is a suspension of 10% Trimethylamine aminated, chloromethylated copolymer of styrene & loinylbenzene, hydroxide; together with 4% Triethanolamine and a water-washable base of 20% Propylene glycol, 1% Benagel E W and 65% water.

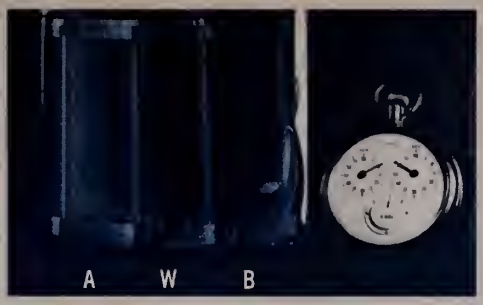
ADMINISTRATION AND DOSAGE: Directions for use: Shake the bottle. Apply liberally to the affected area with moderate rubbing and allow to dry. Allow film to remain on the skin for one-half hour, then wash area thoroughly with water and dry. Applications should be made three or four times daily.

PRECAUTIONS: Residerm has been found to be safe and non-irritating when applied as directed. However, it should not be used for a period longer than 14 days and, if signs of irritation or sensitivity to the drug appear during this period, its use should be discontinued.

HOW SUPPLIED: Available as 1-3/4 fl. oz. in polyethylene bottles.

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An uncoated tablet, Wigraine completely dissolves in 4 minutes, 3 seconds (see photo). Ogden[1] states that "...it is advantageous to secure the pharmacologic effect as quickly as possible." Migraine patients know that this can be the difference between rapid relief and the agony of prolonged headache. Contrasted with Wigraine, Tablet A begins to break up only after 10 minutes, 50 seconds. Tablet B starts to dissolve only after 59 minutes, 13 seconds. (Experiment compared the dissolution speed of Wigraine with two other widely-prescribed migraine therapies. U.S.P. Tablet Disintegration Apparatus was used in artificial gastric juice.)

completely dissolves in 4 min., 3 sec.
treats the complete migraine syndrome

Wigraine®

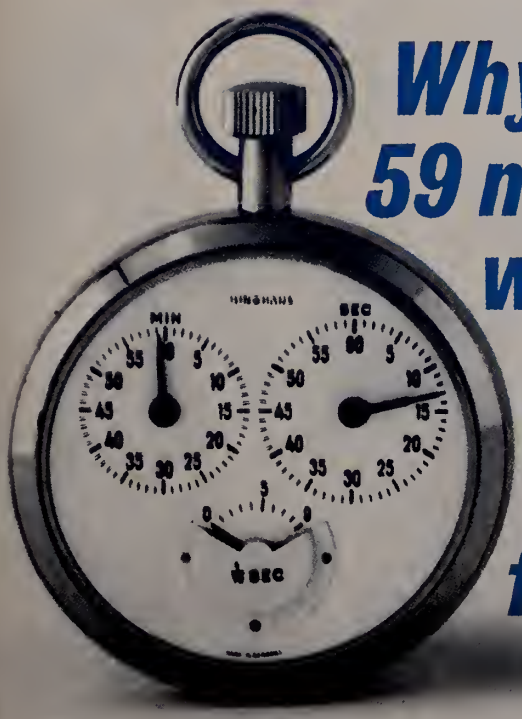
each Wigraine tablet contains:

ergotamine tartrate 1 mg. and caffeine, 100 mg. to abort the migraine attack; 0.1 mg. l-belladonna alkaloids, to control the GI distress, nausea; and phenacetin, 130 mg. to relieve the second source of pain: sustained contraction of head and neck muscles.

Dosage: 1 or 2 tablets as early in the onset as possible, preferably during the characteristic prodromal stage; then 1 or 2 every 15 minutes until pain subsides (maximum of 6 tablets per attack.) Same dosage for suppositories. **Precaution:** Dosage of either tablets or suppositories singly or in combination should not exceed a total of 12 during any seven-day period. No serious complications reported in recommended dosage. **Contraindications:** peripheral vascular or coronary disease, angina pectoris, hypertension, renal or hepatic dysfunction, pregnancy, septic states, incipient glaucoma. **Supplied:** boxes of 20 and 100 tablets, 12 rectal suppositories.

1. Ogden, H.D.: Headache 5:49-55 (July) 1965.

Organon Organon, Inc. West Orange, New Jersey 07052



Why wait 59 minutes when you can use Wigraine for migraine?

IMPORTANT FACTS

about

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Insurance that only covers claims based on the rendering of, or failure to render, professional services, or arising out of malpractice error or mistake in rendering professional services, is no longer adequate.

Our policy, approved and recommended by The Medical Society of New Jersey is broad enough to cover:

(1) the non-negligent as well as the negligent claim, such as arising out of duties as committee member in your society or hospital.

(2) The financial loss to a physician in attending trial as a defendant in protracted litigation.

(3) punitive damages for libel or slander.

This program, which was designed with The Medical Society of New Jersey and its legal counsel, and operated by a cooperative Loss Control Program, offers this broad protection, security and continuity of coverage.

Complete protection should not
be controlled by price.

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after surgery

B and C vitamins are therapy: Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS capsules, designed to meet increased metabolic demands, aid in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.



Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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*Marks, V., and Dawson, A.: Brit. M. J. 1:293, 1965.



DEXTROSTIX—
provides a clinically useful determination when performed according to directions†

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Yes—all your patients

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Elkhart, Indiana

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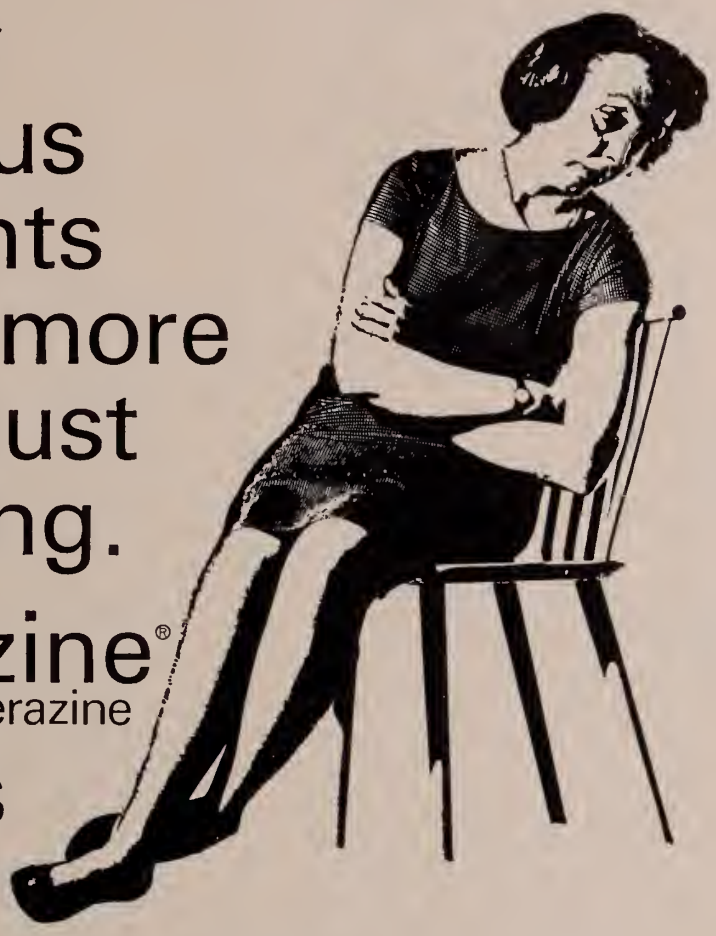
09165

Many anxious patients need more than just calming.

Stelazine®

brand of trifluoperazine

offers true tranquilization.



Sedative or muscle relaxant-type tranquilizers are often all that's needed for patients with temporary situational anxiety. But in the many patients whose anxiety presents a continuing problem these agents are limited by their generalized dulling effects.

'Stelazine' can attack anxiety directly without producing annoying dulling effects. On 'Stelazine', patients can react more normally to day-to-day stress yet remain alert, able to carry on their normal activities.

Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems. Before prescribing, see SK&F product Prescribing Information.

SK&F Smith Kline & French Laboratories, Philadelphia

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HIGHEST
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4 1/2 %

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Liberty	$ 54.95		$349.00
St. Gaudens	$ 54.95	**$2.50 Gold pieces**	
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Liberty	$ 32.95	Indian	$ 32.95
Indian	$ 52.95	**$1 Gold pieces**	
$5 Gold pieces		Type 1	$ 49.95
Liberty	$ 23.95	Type 2	$250.00
Indian	$ 32.95	Type 3	$ 75.00

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Liberty Gold Type Set	4 Coins	$159.95
Indian Gold Type Set	4 Coins	$169.95

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U. S. SILVER DOLLARS	Single	$2.00
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Bamadex® Sequels®

Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



First aid for a button popper



Second aid for a button popper

Bamadex® Sequels®

d-amphetamine sulfate (15 mg.) and meprobamate (300 mg.)
Sustained Release Capsules

By providing combined anorexigenic-tranquilizing action, BAMADEX SEQUELS Capsules help your nonshrinking patients to establish new patterns of eating less. The amphetamine component suppresses the appetite, while the meprobamate helps allay nervousness and tension. And for most patients, the *sustained* release of the active ingredients makes possible convenient one-capsule-a-day dosage.

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Lederle

6655

SOME HELPFUL REMINDERS

. . . on Blue Shield Complementary Coverage under Medicare Part B

It will save time and trouble for you . . . your Medicare patients . . . and Blue Shield . . . if the following points regarding Blue Shield Complementary Coverage are kept in mind:

Blue Shield cannot act on a claim for Complementary benefits until the Part B carrier has paid the Medicare portion of charges.

Hence any claim for Complementary benefits must be accompanied by the "Explanation of Benefits" furnished by the Part B carrier to the patient, showing the Medicare payment.

THE "65 PROGRAM"—"Blue Cross and Blue Shield 65" program covers in-hospital services only. For these it pays the $50 annual deductible (or any part incurred for in-hospital services) and the 20 percent balance of the physician's reasonable charges, as determined by the Medicare Part B carrier.

"CARVE-OUT" PROGRAMS—The other Blue Shield Complementary Programs, known as "carve-outs," cover the difference between the Blue Shield scheduled allowance (or the physician's charge, if less) and the payment made by the Medicare Part B carrier.

All services which are eligible under the basic Blue Shield Subscription Certificate, as well as any Blue Shield Riders held, and which are also eligible for Medicare benefits, are covered for Blue Shield Complementary "carve-out" benefits.

ADDITIONAL SERVICES COVERED — In addition, Complementary "carve-out" programs include special Blue Shield coverage for services personally rendered and billed for by "hospital-based" specialists — radiologists, pathologists and physiatrists — which have been traditionally covered by Blue Cross as hospital services.

BLUE SHIELD ®
MEDICAL-SURGICAL PLAN OF NEW JERSEY
500 Broad Street, Newark

Most of my patients with high blood pressure are as old as I am. A lot of them are living on pensions. They're grateful when I can keep prescription costs down.



Regroton®

chlorthalidone 50 mg. reserpine 0.25 mg.

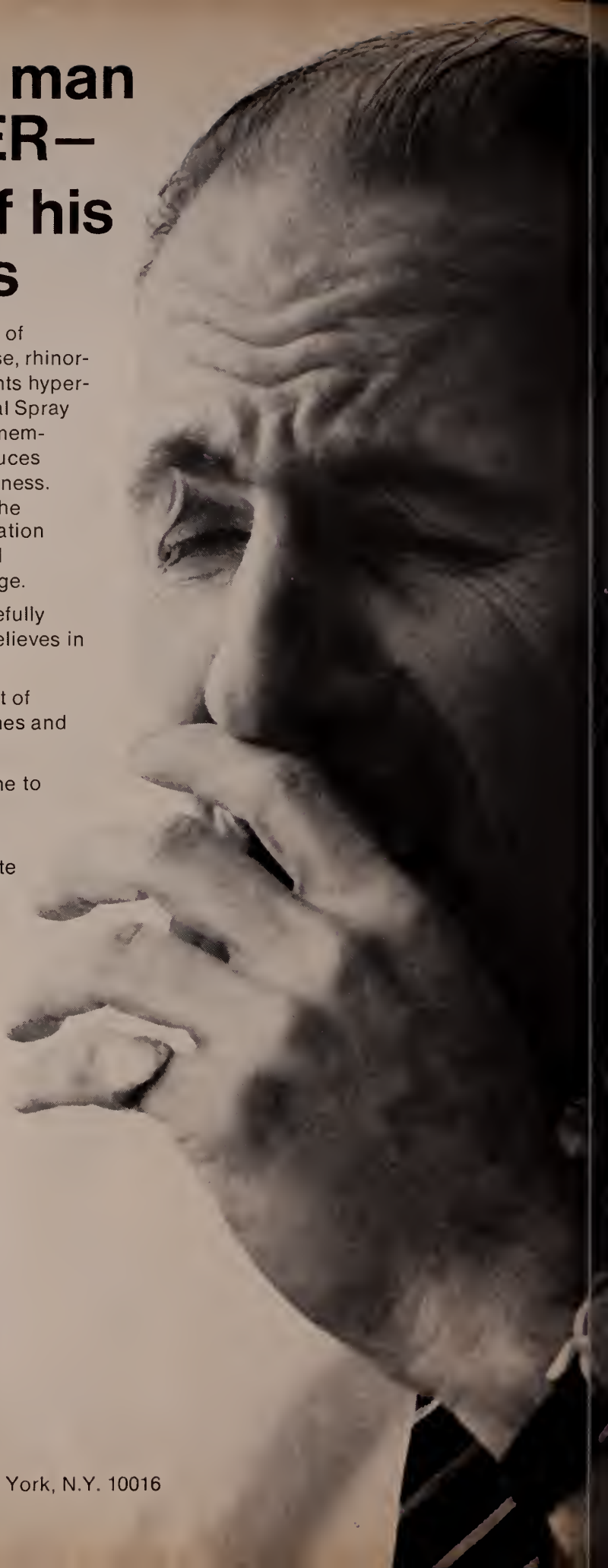
1 tablet daily brings pressure down

Advantage: Both components of Regroton are long-acting.
Average dosage: One tablet daily with breakfast.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness. For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

Geigy

Once merely a man with HAY FEVER—

now a victim of his own antibodies



Whatever term describes him in this new era of immunology, the symptoms of congested nose, rhinorrhea and sneezing haven't changed in patients hypersensitive to pollens and molds. But NTZ® Nasal Spray relieves the symptoms. It decongests nasal membranes on contact, relieves itching and reduces excessive rhinorrhea without unpleasant dryness. The first spray of well-tolerated NTZ shrinks the turbinates, helps restore normal nasal ventilation and breathing. After a few minutes, a second spray enhances sinus ventilation and drainage.

More than a simple vasoconstrictor, the carefully balanced formula of effective components relieves in three ways with:

- **N**eo-Synephrine® HCl 0.5%, a decongestant of unexcelled efficacy to shrink nasal membranes and allow more comfortable breathing.
- **T**henfadil® HCl 0.1%, a topical antihistamine to help relieve itching and rhinorrhea.
- **Z**ephiran® Cl 1:5000, an excellent wetting agent and antiseptic preservative to promote the rapid spread of components to less accessible nasal areas.

Supplied in convenient pocket-size plastic spray bottle of 20 ml. Also available as a solution of 30 ml. (1 fl. oz.) with dropper, and 473 ml. (1 pint).

Prescribe

NTZ® Nasal Spray

(contains Neo-Synephrine HCl)

Winthrop Winthrop Laboratories, New York, N.Y. 10016

Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.



mood elevation

Abbott
Anorectic
Program

DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.



controlled release

Abbott
Anorectic
Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

That's why the Gradumet provides controlled-release as well as long release.

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

Abbot
Anorecti
Progran

DESOXYN Gradumet
Methamphetamine Hydrochloride in Long-Release Dose Form

5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium

Front Side

DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium

Front Side

samples available



Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.



economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

ABBOTT

Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445
Sucaryl—Abbott brand of low and non-caloric sweeteners.

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Here's new protection created only for professional men and women that covers any fixed expenses, normal and customary to the operation of your practice, except your salary and cost of implements and merchandise.

Here are some of the outstanding features of protection you receive in Continental Casualty's Overhead Expense Policy: Protects you 24 hours a day • House-confinement NOT required • Premiums deductible as a direct business expense. Accident coverage immediately after your policy's effective date and sickness originating 30 days thereafter • Joint occupancy (partnership) protection for your portion of the fixed expenses within the same limits.

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Your policy has been designed to allow you the specific advantage of Internal Revenue Ruling (55-265, I.R.B. 1955-19, p 8) which authorizes certain business and professional men and women to use the premiums for this policy as a direct business expense for tax deduction purposes.

To help reduce the cost of Overhead Expenses Protection, this policy PI-50099-A does not cover loss by war, suicide, military service, pregnancy, or flying other than as a passenger in a certified aircraft.

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30 Clinton Street, Newark, N. J.

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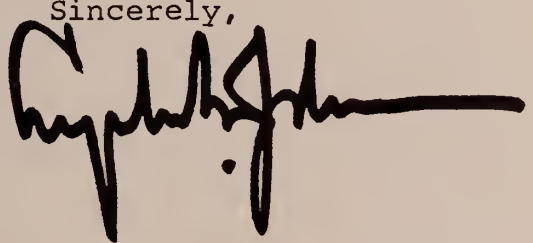
Dear Dr. Bedrick:

For two centuries--a period which precedes the birth of this nation--the generations of physicians who established and advanced The Medical Society of New Jersey have given enlightened attention to the health and social problems of our people. They have contributed significantly to the solution of these problems.

I share your pride in your history and in the accomplishments of your members, both as physicians and as citizens.

It is a pleasure to congratulate The Medical Society of New Jersey on your Bicentennial and to extend best wishes for the future.

Sincerely,



Dr. John J. Bedrick
President
The Medical Society of New Jersey
Post Office Box 904
Trenton, New Jersey 08605

EDITORIALS

Our New President



Our new President, Joseph Jehl, M.D., has his roots deep in New Jersey. He was born in Passaic County, and he is still there. But between then and now, he has been around. Having been graduated from Clifton High School, he went to New York University and then to Bellevue, where he earned his M.D. in 1932. He interned at St. Joseph Hospital in Paterson, and then went on to several hospitals in New York City for a residency in obstetrics, and later in pediatrics. After that he did general practice until 1942, when, like so many of us, he accepted a commission in the Medical Corps of the Army of the United States. He was Battalion Surgeon to the Seventh Armored Division during much of that time. On being mustered out at the end of the war, he decided to limit his practice to pediatrics and has done so ever since. He is now Attending Pediatrician at St. Joseph Hospital. He is also interested in allergy, and has been active with our state's allergy society. Dr. Jehl has also been busy with civic affairs, having served, for example, as President of the Clifton Rotary Club. He has been a sparkplug in the Homemakers' Services, in the Tuberculosis and Health Association, and the Red Cross. In his own county society (Passaic County Medical Society) he has filled all the official chairs with distinction and was President of that component in 1955-56.

In 1934 he married Winifred Tyler, and he and Mrs. Jehl now have a son, a daughter, two grandsons and two granddaughters — a well-balanced family, indeed!

Dr. Jehl has always been more than just one additional member. He has, for example, served with the Speakers' Bureaus of many of his organizations — including the American College of Allergists (of which he is a Fellow), the Association of Military Surgeons, and the American Association of Physicians and Surgeons.

Bicentennial Commemorative Issue

This special bicentennial commemorative issue has been prepared — and is presented — by the Publication Committee and Editorial Staff as THE JOURNAL'S contribution to the Society's Bicentennial Year.

Since a detailed record of the Society from its founding in 1766 to its present anniversary year will be published in a separate book (see page 275), this special bicentennial commemorative issue of THE JOURNAL highlights the Society's Bicentennial Celebration at the 200th Annual Meeting in Atlantic City, May 14 to 18, 1966. This commemorative issue features a pictorial review of the annual meeting events as well as those papers and speeches of the Bicentennial Day presentations.

We hope this issue will prove interesting and enjoyable to the members of our Society and to all our readers. And when Society members in 2066 are searching the "old journals" of our day in preparing for MSNJ's 300th birthday, we hope that they will have some admiration for our efforts and accomplishments in bringing this chronicle to you.

George B. Sharbaugh, M.D.
Chairman, Publication Committee

Good Character As Part Of Professional Fitness

Men of evil character may, of course, be intelligent, skillful, and extremely competent at various trades and crafts. Would, however, a serious character defect bar a man from practicing medicine? The New York Appellate Division apparently thinks so. It considered the case of a physician in New York State who had pleaded guilty to a violation of a federal statute in that he had tried corruptly to influence the administration of justice. The crime, a felony under federal law, was only a misdemeanor under New York State law. For conviction of a misdemeanor, professional discipline is permissive. The doctor was charged with unprofessional conduct and his license was revoked. The doctor contended that the unprofessional conduct for which discipline was imposed was unconnected with medical practice. Despite this contention, the Appellate Division* approved the license revocation stating: ". . . unprofessional conduct on the part of a physician is not limited to acts directly relating to his treatment of patients. . . . The acts committed were so heinous as to negate the contention that respondent possesses the high degree of good character which is expected of a member of the medical profession. The public has the right to expect from the medical profession the highest degree of integrity. We find respondent's conduct was so reprehensible as to indicate that he does not possess such integrity and that such conduct reflects most unfavorably on the medical profession."

The public has a right to expect from the medical profession the highest degree of integrity. So said the judges; and so say we all.

Marion Glazier



Marion Glazier, who heads up our Woman's Auxiliary for 1966-67, was born in Newark from Holland-Dutch stock that had been active in New Jersey for over three centuries. She served in 1950 as President of the Auxiliary to the Essex County Medical Society. Mrs. Glazier was, for some years, a chemical research librarian. She had long duty as a Girl Scout leader. She has served as president of the South Orange Women's Club. She has been a PTA officer. She has been active in many health and welfare organizations, and was one of the pioneers in developing practical nursing courses in her county. She is an officer of the Woman's Auxiliary to the United Hospitals of Newark.

* 24 App. Division Second 699; 261 NYS Second 635.

BICENTENNIAL GENERAL ASSEMBLY

A Civic Appraisal

The Medical Society of New Jersey

Richard J. Hughes
Governor of New Jersey / Trenton

The briefest civic appraisal of The Medical Society of New Jersey would be to list those things that would not exist without it: laws regulating medical practice (as far back as 1772); licensing of physicians; accurate records of vital statistics; laws to encourage water pollution control and milk purification; high hospital standards; establishment of a State Health Department; a non-profit health and hospital care plan (they fostered what became the original Blue Cross and Blue Shield plans); high standards in nursing homes; plan giving convicted drug addicts chance for sustained treatment rather than prison.

In short, the Society has associated itself with almost every forward-looking health and medical development in New Jersey history.

From its inception in 1766, the Society has shown an interest in medical and scientific education, which continues through to its 200th anniversary.

The Society was strong from the outset on regulatory practices. It was the first organized group in the State given the privilege of granting the M.D. degree. A recent book on health in New Jersey said: "Legislators look on the Medical Society as a watchdog of medical standards."



Although it is an organization obviously dedicated to the professional standing of its members, The Medical Society of New Jersey exemplifies the importance of voluntary organizations in this State. Each group found a need to organize for its own ends. But each, sooner or later, resorted to the Legislature for assistance and support.

The history of medicine and health and related education in New Jersey shows this voluntary-government association working for the public good to meet medical and health problems growing out of industrialization, urbanization, and the complexity of our society. The problems were numerous — mosquito infestation, water pollution, dairy pollution, control of smallpox, diphtheria, polio. All defied the knowledge and capabilities of the single doctor working alone. Social action was necessary to wipe them out.

Recent examples of Society-Government cooperation are the massive polio immunization

programs of 1963 and 1964. Three and one-half million New Jersey citizens received the Sabin vaccine, thus immunizing 51 per cent of the entire population. Polio has virtually been eliminated from New Jersey, and the Society gave energetic leadership to that program.

The Society is cooperating fully with the State in implementation of the Medicare program. It offered to the State the cooperation of its component societies in establishing county review committees for extended care facilities. The Health Department and the Society are also working closely to develop utilization review procedures for hospitals and extended care facilities.

Component organizations in the Society work with the State in the control of tuberculosis, measles, and cancer, especially through the Inter-Agency Council on Smoking.

An important sustained activity of the Medical Society has been the investigation and prevention of maternal deaths.

The list of cooperative areas is long, but there are *new areas* with which the Society must concern itself:

First, continued strengthening of the New Jersey College of Medicine and Dentistry and support for the Rutgers School of Medicine, and new programs for nursing training.

Second, need for revision of Hill-Burton Act as it relates to funds for the modernization of older hospitals serving the core cities of our State. The hospital and health revolution will call on all our professional and institutional resources to meet the health needs the people expect will be met.

Third, the vast improvement needed in local New Jersey public health services which was thrust a full step forward with the signing this week of the State Health Aid Act, which provides $2.3 million in State aid. There is an obvious need for a publicly supported training institution for public health workers and officers, which New Jersey needs badly (350 municipalities now have no local health officer).

Fourth, the growing need for some State support to local community hospitals, especially in the area of mental health and psychiatric care. (The Society in earlier years was responsible for New Jersey's setting up the first State Mental Hospital.)

Fifth, the Society should involve itself in the Junior College revolution, making sure that needed technicians and health aides are adequately trained in these institutions.

We are in the midst of a health revolution at all levels of society in the country. New Jersey must assure itself that we lead rather than follow in that revolution. The history of this State and the record of this Society assure us that New Jersey will continue to be a leader, and that the health of the people will be protected and improved.

State House

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An Historical Appraisal

The Medical Society of New Jersey

Morris Fishbein, M.D.*
Chicago, Illinois



In 1623 the Dutch came to Gloucester County in New Jersey and in 1627 the Swedes. Controversies between the English and Dutch governments discouraged immigration until the British won in 1664. An eminent historian said that occupation by the Dutch had been of so little avail that in 1634 not a single white man dwelt within the Bay of the Delaware. A Royal Charter by Charles II in 1664 to the Duke of York included the provinces of New York, New Jersey, and all other lands appertaining. The Duke conveyed to Lord Berkeley and Sir George Carteret all that part of his grant now included in the State of New Jersey.

In the beginning there were no doctors. However, the clergy who left England for the new land combined medicine with their theological leadership. Clergymen drew wills, also contracts and state papers, settled controversies, and instructed the young. Many of these clergymen obtained some knowledge of medicine and wrote medical papers, which were among the earliest medical papers printed in America. The Quakers, who were the earliest occupants of West Jersey, brought physicians who had been trained as such. Many of these doctors, however, undertook also land speculation, merchandising, farming, and other remunerative pursuits. Such a mixture of doctors it was who, in 1766, founded the New Jersey Medical Society on July 23 at New Brunswick.

Most of what I shall relate has been obtained from consultation with the original transactions of the New Jersey Medical Society and from a book published by Dr. Stephen Wickes in 1879 called "History of Medicine in New Jersey and of Its Medical Men from the Settlement of the Province up to A.D. 1800." In 1875 the New Jersey Medical Society decided to publish its "Transactions" from 1766 to 1800. Dr. Wickes edited that volume. He found in the transactions a few historical addresses, and he was much helped by notes of the Honorable Judge Bradley of the U.S. Supreme Court, who had come from Essex County.

What was medicine like in New Jersey in those early days? A man named Charles Gordon, who lived at Woodbridge in East Jersey, wrote to his brother in England suggesting that he come to the new land. He suggested that he "come as a planter, or a merchant, or as a doctor of medicine. I cannot advise you, as I can hear of no diseases here to cure, but some agues and some cutted fingers and legs, but there are no want of empiricks for these already. I confess that you could do more than any yet in America, being versed in Chirurgery and Pharmacie, for here are abundance

* Dr. Fishbein is professor emeritus of the Department of Medicine, University of Illinois College of Medicine; medical author and editor, Chicago, Illinois.

of herbs, shrubs, and trees, and no doubt medicinell ones for making drugs, but there is little or no Imployment this way." Perhaps Charles Gordon was just trying to be discouraging!

Another traveler wrote in 1748, saying "An old Swede remembered that his mother cured many people of dropsy by a decoction of the root of sassafras in water, but she used at the same time to cup the patient on the feet."

And finally, a physician who settled in Boston in 1718 said, "In our plantations, a practitioner, bold, rash, impudent, a lyar, basely born and uneducated, has much the advantage of an honest, cautious, modest gentleman. In general, the physical practice in our Colonies is so perniciously bad, that excepting in surgery and some acute cases, it is better to let nature take her course than to trust to the honesty and sagacity of the practitioner; our American practitioners are so rash and officious, that the saying of the Apocrypha may, with propriety, be applied to them: 'He that sinneth before his maker, let him fall into the hands of the physician'."

The practice of those days consisted largely of blistering, bleeding, vomiting, purging, and anodynes. These methods were pursued ad libitum until the patient either recovered or died. It was an era of pestilence and ignorance. Smallpox had spread from the Indians. Venereal diseases were widely disseminated by the immigrants. An epidemic of influenza appeared — the first of which there is any record. One observer wrote: "It came with the cold and in many accompanied by a light fever. Such as bled or used cooling drinks, died. Such as made use of cordials and more strengthening things, for the most part recovered." What a testimonial for whisky!! The condition appeared again in Europe in 1767 and apparently afflicted horses, particularly in New England and New Jersey. In 1735 a "throat distemper" described as malignant, which might have been epidemic sore throat or diphtheria, spread throughout New Jersey. Children died by thousands. Hardly a city in America at that time had a population as large as 7000. In New Jersey a remedy was published. The recommendation said: "Take some honey and the sharpest vinegar with alum dissolved therein and let the patients often gargle their throat, or if they be children, then take a feather and dip it in said liquor, and so wash their throats." The treatment in other places was a sort of teriac full of roots and vegetables with little that could have been of any real value. Scarlet fever appeared and was as deadly as the plague in Europe. Then came yellow fever in 1618 and as late in other places as 1699 described as "the most deadly pestilence plague that ever affected the people of this country." In 1721 the famous Cotton Mather recommended an inoculation for smallpox, as it was practiced in Turkey; but physicians in Boston treated the recommendation with indifference. Dr. Zabdiel Boyleston adopted the practice in Boston in 1721, inoculating first his only son, aged 13, and two Negro servants. Strangely not many doctors but most of the clergymen supported the practice. Benjamin Franklin condemned it in his brother's newspaper but later his opinions changed when his 4-year-old boy got smallpox. Franklin wrote, "In 1736 I lost one of my sons, a fine boy of 4 years, by the smallpox, taken in the common way. I long regretted him bitterly, and still regret that I had not given it to him by inoculation."

A special hospital for smallpox was opened in Boston in 1764, and this is mentioned now because Dr. Barnett of Elizabethtown, New Jersey, who was an enthusiast for inoculation and who had acquired a reputation for this specialty, was invited from Elizabethtown to Philadelphia to inoculate for the smallpox in 1759.

A few pamphlets had been published in the United States before 1766, but as far as I can determine not yet any medical periodical. However, a few papers were published in transactions of some of the societies, particularly the American Philosophical Society, which published its first volume in 1771.

Here Dr. Samuel Bard, who developed Columbia University College of Medicine and who owned the property where Radio City now stands, wrote on what was called "The Sore Throat Distemper," which was clearly diphtheria. One doctor in New Jersey imported a book from England in 1698, paying the expenses of a messenger to go to England for it. It was "Salmon's Herbal," entirely made up of descriptions of plants and their virtues in disease.

There was only one medical college in the United States before 1766. That was the one in Philadelphia headed by the famous Dr. William Shippen and Dr. John Morgan. This is the Morgan who tried to trace his relationship to the famous Morgagni of Italy, one of the founders of pathology. The College of Philadelphia, founded in 1759, elected Dr. Morgan "professor of theory and practice of physic" and, in the September following, Dr. Shippen was elected "professor of anatomy and surgery." This was the medical school! Later in 1767 lecturers were appointed on materia medica, chemistry, and clinical study.

An interesting little group assembled July 23, 1766 in Mr. Duff's place in New Brunswick. A notice had been inserted in the New York *Mercury* informing doctors about the organization in prospect. The notice read:

> A considerable number of the Practitioners of Physic and Surgery, in East New Jersey, having agreed to form a Society for their mutual improvement, the advancement of the profession and promotion of the public good, and desirous of extending as much as possible the usefulness of their scheme, and of cultivating the utmost harmony and friendship with their brethren, hereby request and invite every gentleman of the profession in the province, that may approve of their design, to attend their first meeting, which will be held at Mr. Duff's in the city of New Brunswick, on Wednesday, the 23d of July, at which time and place the Constitution and Regulations of the Society are to be settled and subscribed.

They adopted a constitution for the New Jersey Medical Society containing some principles of ethics — about 16 of them — which reads like Percival's Principles of Ethics (which, however, was not written until 1803). I do not know whether or not Percival had any knowledge of this previous document which may well, however, have stemmed from some other documents of similar character. The Principles of Ethics of the American Medical Association, adopted after organization of that body in 1847, definitely derived from the New Jersey principles and Percival's principles.

A short lived medical society appeared in Boston as early as the 1730's and a few other small societies had been set up in various places, but in 1766 the pioneer, state, or provincial society was established in New Jersey. In that same year Morgan formed the Philadelphia Medical Society, which he hoped would evolve into a college of physicians. But it was absorbed into the American Philosophical Society. However, the College of Physicians of Philadelphia was founded in 1787.

The first medical libraries in the United States were established in the Pennsylvania Hospital in 1762 and in the College of Physicians of Philadelphia in 1788. When the Revolutionary War came on, as might be expected, state medical societies began to be formed following the example of the one in New Jersey. Ten years after the war ended, there were medical societies in five other states, and by 1815 nearly all states had them.

One of the first activities of the New Jersey Medical Society was the adoption of a fee list. A few items are fascinating. There was no charge for a visit in town if the doctor could attend the patient without riding, but he could charge later according to the duration of the ailment and the amount of attendance. If the case lasted a long time and required daily care and attendance, the charge was 10 shillings per week — in modern money $1.40 — and that must be considered to be well above what it was worth in those days! Any visits out of town under half a mile were on the same basis as in town; but out of town, the charge was a shilling for 1½ miles. If you lived as far as 25 miles, you had to pay 2 shillings for every mile above 25. Consultation fees were 15 shillings for the first visit and half of that for every succeeding visit. The fee bill covers every possible kind of medical and surgical

activity. Delivering a woman in a natural case was 1 pound 10 shillings; if complicated, 3 pounds; and if forceps were involved, also 3 pounds. The doctors did their own dispensing, using principally such drugs as rhubarb, emetics, cathartics, cream of tartar, tinctures, and calomel. For example, gonorrhea, including calomel, the charge was 2 pounds 5 shillings; gonorrhea attended with chancres or particular trouble was also 3 pounds.

Another activity of the Society was to persuade the state legislature of 1772 to provide licensing restrictions and to establish a provincial licensing board. This also was the first such agency in the United States, except for a small local body in New York City. This examining board set the pattern for most states until 1830. Since most of those who applied for membership and for licensing were not trained, the regulations required them to serve an apprenticeship of three years with a reputable practitioner. Candidates who had an arts degree were required to serve only two years. Those who were medical graduates were exempted from all requirements, but they had to have a letter from Dr. Shippen or Dr. Morgan or some European body of equal importance to prove their training.

In 1769 the New Jersey State Medical Society began to be concerned about the little societies in towns like Elizabethtown, Princeton, and similar areas, and adopted a law to regulate inferior medical societies that wanted to affiliate with the state society.

At various sessions of the New Jersey Medical Society they met not only in Mr. Duff's place but also once with the widow Vorhes and occasionally in the homes of various distinguished citizens.

The first president of the New Jersey Medical Society was a clergyman.

I have been especially impressed by the high ideals of the group who first called the doctors together and by their first constitution. They addressed themselves to enlarging the stock of knowledge and experience. They agreed not to enter any house except for the good of the patient. They wanted consultations. They opposed secrecy in drugs and pledged themselves to maintain harmony and brotherly affection in their society. They promised most readily and cheerfully to assist gratis "by all means in our power, the distressed, poor, and indigent." However, when legal provisions were made, they said "we shall expect a reasonable reward from the particular town or county to which such poor may belong."

They agreed to hold meetings twice yearly and agreed to attend every meeting and to pay a fine of 3 pounds when absent. They also provided for examinations of those who would join with them, and finally they said: "Lastly, this society will do all in their power to discourage and discountenance all quackers, mountebanks, imposters, or other ignorant pretenders to medicine."

The Society also began to improve its knowledge by an occasional paper read either by the president or one of the members. The subjects during the first few years concerned the causes and methods of cure of diseases of infants, inoculations against smallpox, pleurisy, the nature and properties of the blood, the formation, use and sympathizing quality of the nerves, nephritis or inflammation of the kidneys. After the war a paper was read on "Health and Disease;" another on "Mechanism of the Human Body," which divided the body into two kinds of material — fluids and solids. Then in 1785 some case reports appeared and cases were presented before the Society. One was a case of spina ventosa of the two lower dorsal vertebrae. The members of the Society solemnly observed this patient, and the minutes say "the general opinion was that it is incurable." In 1786 a case of harelip was presented, and the Society solemnly agreed that since the child was only five months old, nothing had better be done about it except do the best that can be done with plasters.

During the war the New Jersey Medical Society, as well as all similar organizations in the

United States, lapsed, one of the reasons being a resolution adopted at that time that they were opposed to British oppression and tyranny and that, anyway, travel was unsafe and impractical.

I was especially interested, also, in a paper read at a meeting in 1788 held at Burlington, when four doctors were penalized for not coming to the meeting. The Society met at the house of James Drake at New Brunswick, and a Dr. Elmer discussed the different properties of air contained in the atmosphere. He had become familiar with the writings of Lavoisier. It was concerned with phlogiston, and his address is a combination of all of the little knowledge and vast superstition which then prevailed about air and gases.

I was also especially interested in following the account in the transactions of the Society of the case of Dr. Berne Budd, one of their members, in 1769 who "had in sundry places misrepresented the designs of its institution, whereby a number of gentlemen of the Faculty have been prejudiced against becoming members, and many persons against the Faculty in general." A committee was appointed to look into this matter. Six months later the committee reported that they had made diligent inquiry respecting the conduct of Dr. Budd and asked that he appear before the Society at its next meeting six months later to "exculpate himself if innocent." In November, however, Dr. Budd did not appear to give any account of his conduct nor did he write to the president. So the Society, "not being desirous to act with severity, if it can consistently be avoided, ordered the Secretary to write to him and order him to appear at their next general meeting." Now it appears again in May 1771 that Dr. Budd exculpated himself to the satisfaction of the board and gave good reasons why he did not attend the meetings. He began, however, to miss meetings again, and in 1773 was again called on to explain his absences. His excuses were accepted, but in November 1773 Dr. Berne Budd "having fallen into a most criminal deportment as a public delinquent and offender against the dignity and majesty of our most gracious King and Sovereign, a motion was made and seconded, in consequence of which, the Society unanimously agreed to expel from their Board the said Berne Budd, as a person really scandalous, and altogether unworthy the notice of its members."

The first member of this Budd family was Thomas Budd, who was a rector from Somersetshire, England. He renounced his benefice and became a Quaker, and his son Thomas Budd came to Burlington, New Jersey, in 1668. In 1678 he came back, bringing along his brothers William, John, and James with their families — 25 people in all. They were industrious, bought property. One moved to Philadelphia and became a merchant. James Budd stayed in New Jersey, was drowned in the Delaware River at Burlington in 1692. Berne Budd was born in 1738, the son of John Budd, who had gone to Philadelphia. He moved into Morris County soon after his father's death and began to sell the land belonging to the family. He had children, of whom three were doctors — Dr. John, Dr. Thomas, and Dr. Berne. They gave up the religion of the Friends, but Dr. Berne Budd, his son, married Phebe Wheelers of Morris County and got involved in the crime of "counterfeiting bills of credit of the province of New Jersey." He was associated with a gang headed by Samuel Ford of Morris County. The doctor and three others were convicted and sentenced to be hung. However, the professional skill of Dr. Berne Budd was held in such high repute that his conviction of crime and having been sentenced to death did not prevent his retaining his practice. He was, however, financially in trouble. He was sued for debt several times. Then when the war started, he was appointed a surgeon in the Army in September 1777 and died of "a putrid fever three months after" and was buried on the Budd farm two miles from Morristown, New Jersey. No stone marks his grave.

His brothers Thomas and Daniel Budd were also involved in the war. One joined the Navy and was blown up on board a warship by the British, everyone on the boat perish-

ing. Daniel Budd studied medicine in Philadelphia, became a member of The Medical Society of New Jersey in 1772, joined the Continental Army out of Schenectady as a surgeon, and was with Washington when he crossed the Delaware and at Valley Forge. After the war he returned to Schoharie to practice medicine. He had obtained a good deal of money through his family. It is reported that he occasionally overindulged in liquor and neglected his business. One report says "he was a poor collector and never hardly charged the poor for his professional services." He became an Episcopalian. A great monument in the Lutheran Church Cemetery in Old Schoharie, New York, stands as a testimonial to his credit. There were many other Budds who became physicians. The family deserves a special book for itself.

During the Revolutionary War after the Battle of Long Island and the occupation of New York by the British, Dr. William Shippen under an act of Congress provided and superintended a hospital for the army in New Jersey. Hospitals also were established at Amboy, Elizabethtown, Fort Lee, New Brunswick, Trenton, and Newark. Dr. John Morgan was director-general of the Continental Army and some controversy arose between him and Dr. Shippen because Shippen complained that he "could not take charge of nearly 2000 men scattered up and down the country in cold barns who suffered exceedingly for want of comfortable apartments because Dr. Morgan does not understand the meaning of the Honorable Congress and apparently still thought that all the troops were under his direction. Shippen wrote that Dr. Morgan had gone to see General Washington to get his opinion. Dr. Morgan wrote a considerable vindication of himself. After the Battles of Brandywine and Red Bank in 1777, a general hospital was opened at Princeton in the college buildings. In February 1777 General Washington addressed the Congress from Morristown, New Jersey, saying: "The smallpox has made such head in every quarter that I find it impossible to keep it from spreading through the whole army in the natural way. I have therefore determined not only to inoculate the troops now here that have not had it, but shall order Dr. Shippen to inoculate the recruits as fast as they come to Philadelphia."

More than 50 New Jersey doctors were commissioned in the War of 1776.

When the New Jersey Medical Society met at its 81st annual meeting in New Brunswick in 1847, three cases of hydrophobia were reported by Dr. William Pierson, which are full of interesting comments, particularly a warning against ignorant charlatans who offered remedies and made claims for them without regard to the fact that many persons who are bitten do not necessarily succumb to the virus. All three cases of hydrophobia died within 48 hours after the symptoms appeared.

Especially interesting in the report for that year was a statement which follows:

> Under the head of "new discoveries" in medicine, your reporter wishes briefly to notice the vapour of sulphuric ether as a remedy for the alleviation of pain in surgical operations. It has been but a few months since the attention of the profession was directed to this subject, from the fact of a certain dentist in Boston procuring a patent for the discovery of a method for relieving pain in dentistical operations. Doctors Warren, Hayward, Bigelow, and others connected with the Massachusetts General Hospital, first allowed the vapour to be administered on the 17th of October, 1846, to a patient under their care, upon whom the operation of removing a tumor from the neck was performed while under its influence. Though this experiment was not entirely successful in relieving the pain, as was anticipated, it was sufficient to convince Dr. Warren (the operator) that the effect of this gaseous inhalation was to "neutralize the sentient faculty;" and he believed that if properly administered it would be a valuable aid to the surgeon, in his efforts to alleviate human suffering. Upon investigation it being ascertained that the vapour of sulphuric ether alone — separated from its impurities by washing — without the addition of any narcotic drug, was sufficient to produce the desired effect, and the patient being considered invalid, its use was adopted in the Hospital, and has since been employed in that institution. . . .

Then followed reports of various other cases and an announcement that the Acâdemié de Medécine in Paris had a report from Dr. M. Malgaigne that he had tried the American method of rendering surgical operations painless on five patients with great success in almost all cases, but the New Jersey reporters suggested that when the method failed, the

failure was due to a wrong method of administration. This was the first report to the New Jersey society.

In 1848 the Society heard that homeopaths were invading New Jersey. The report said:

Homoeopathists, beyond the pale of our church, are, to all intents and purposes, illegal practitioners, and therefore amenable to the same kind of non-intercourse as Thomsonians or nostrum venders, deserving and demanding from us similar exclusion.

The committee also recommended to the Society "to take under its especial care and attention, some respectable medical journal, or purchase the New Jersey Medical Reporter now published at Burlington." The report says:

. . . and if that cannot be effected, to ascertain by a committee (to report at the next annual meeting) the expediency of commencing a second medical work. The Committee had not the slightest intention of retarding the circulation or injuring in any mode the one now extant; on the contrary, it was with the most delighted feeling they saw its primary annunciation, anticipating the hour (long since passed) that we too, "Jersey Blues," might boast of having written a book. And may we be permitted, Mr. President and fellow-members, to congratulate the whole profession, as well as our Association, on having secured a denizen in our midst, and a medical brother who has executed the task with gratification to us and honor to himself; and we would respectfully call the attention of our medical brethren through the length and breadth of the State thereto.

Your Committee believes the day has arrived that will (with the Society's aid) justify the publication of one large quarterly medical review, as *Hay's Journal of the Medical Sciences*, or two of smaller calibre, similar to that now so agreeably and satisfactorily emanating from Burlington. Whichever of the plans deliberate judgment may select, we think an alliance with our medical pioneer would not only strengthen his press and certainly detract nothing from ours — on the other hand, enhance its usefulness and benefit.

Medically during that year erysipelas, accompanied by typhoid or nervous symptoms, prevailed.

In 1849 the Society received a report which said: "We would commend to the profession the subject of etherization in childbirth, as worthy of more consideration than we believe it has received by physicians of our state." The New Jersey Society began to be greatly concerned with medical education and had presented to it a report of the recent meeting of the American Medical Association in New York which said:

Resolved, That the union of the business of teaching and licensing, in the same hands, is wrong in principle and liable to great abuse in practice. Instead of conferring the right to license on Medical Colleges and State and County Medical Societies, it should be restricted to one board in each State, composed, in fair proportions, of representatives from its medical colleges and the profession at large; and the pay for whose services as examiners should, in no degree, depend upon the number licensed by them."

The Society had started a benevolent fund for the relief of families of regularly licensed physicians who might die in indigent circumstances.

In his presidential address to the New Jersey Medical Society in January 1859, Dr. J. P. Coleman reviewed the history of the society and deplored the fact that the legislature of the state "by the injudicious act of 1854, has, in a measure, paralyzed our power for usefulness" which obviously related to taking away the licensure powers. His mixed metaphors were startling. He said:

The foremost State in the Union, proudly bearing her standard, in advance of all others in social organization, for the elevation of the medical character, has lost her position, and fallen to the rear. The wooden horse has entered, her portals are open, and now it remains to be seen whether her batallia are sufficient for the conflict.

One is reminded in this proud address of the belief expressed in a song in "Oklahoma" about Kansas, which said, "They have gone about as far as they can go."

The national medical association had by this time taken leadership and was guiding the activities of the state societies.

By this time the medical society was having a considerable number of scientific reports in its meetings and had developed a statistical system for recording disease. One of the interesting cases was that of a girl, 14 years old, not married, delivered after a natural labor of four hours of a fine looking boy, weighing nearly 10 pounds.

In 1861 the Standing Committee reported to the Society a request from the American Med-

ical Association to develop a national licensure. This, of course, never was realized, but as to the state of the practice at that time the report said:

. . . The hordes which annually swarm from our medical schools of every grade, far exceed the actual demands even of our rapidly increasing population. With a population of thirty millions, we annually see diplomas granted to 1400 or 1500 new recruits; while in France, with a population of 36 millions, only some seven or eight hundred join the ranks. . . .

In 1864, under the leadership of Dr. S. L. Condict, the Society agreed to help in the establishment of an inebriate asylum. Apparently the Society was not nearly so concerned with the Civil War as in the Revolutionary. However, Dr. Thomas F. Cullen in the annual essay for 1864 spoke on "The Influence of the Present War upon American Medicine and Surgery." He said:

. . . Many of our fellow-members are nobly sacrificing the comforts of home, and in some instances, the emoluments of a rich practice or bright expectations, to serve the country in its need, or to advance themselves in a knowledge of their favorite branch, in the midst of howling shot and screeching shell, the whistle of the minie, the crack of the rifle, the boom of the ordinary artillery, and the prolonged rattle of the musketry.

He was concerned that the medical knowledge gained from the struggle should be made available to all mankind. He noted that the great outbreak of the rebellion found the country totally unprepared for war on a gigantic scale. He said that the medical profession "was swarming with surplus numbers, from the irrational fondness of our citizens for professional honors; they having been strangely considered the only substitutes for aristocratical distinction in this republican land." The country was being overwhelmed, he charged, with isms and cultists.

Perhaps the outstanding performance of 1866 was the celebration of the 100th anniversary described by Dr. A. Coles, president of the Society, as "hoary with the frosts of one hundred winters." The Society convened on January 24 for centennial exercises to which the faculty of Rutgers College was invited. The assessment to district societies was raised from 50¢ to $1.00. Representatives attended from the American Medical Association, the Army and Navy, and medical colleges as well as from many state societies. The president's address by Abraham Coles, M.D., was presented as a poem in which he emphasized religion and the spiritual side of medicine. This poem occupies 45 pages, after which he apologized that because it was so brief, he could not include a number of subjects although he had "castigated some parts."

At that time Dr. William Pierson provided a short history of the society. He called attention particularly to the affiliation of New Jersey to the American Medical Association beginning in 1846 and suspended during the Civil War from 1861-66. He said:

. . . Auspicious association! we hail thee as the instigator and instrument of a higher and more uniform grade of medical education, in its preliminary and professional aspects — the arbiter of a judicious ethical code — the garner where may be gathered the improvements and discoveries in the healing art, and an authoritative judgment pronounced upon their value and adoption. If no higher merit can be claimed in its behalf, we think, its annual re-unions, affording as they do, opportunity for relaxation of labor, and of an extended acquaintance with members of the profession throughout the land, and for the exercise of those amenities and courtesies which belong to our calling, ought to endear this association to every one, who believes that man was not made for toil alone, but for the enjoyment and employment of those social elements which pertain to his nature. . . .

Thus ended the first one hundred years of the New Jersey Medical Society which had contributed vastly to the progress of medicine in this state. During the last 100 years New Jersey has witnessed many significant developments, including continuous reports to establish in the state a medical school of high quality related intimately with a university. With the current shortage of physicians in the United States, the efforts of universities in New Jersey to establish a high quality of medical education are bound to be successful.

New Jersey has become the greatest center for pharmaceutical manufacture not only in the United States but perhaps in all the world. Centers in European countries, of which the greatest is in Basel, Switzerland, are an indication of the significance of this effort for the advancement of medical science not only in New Jersey but throughout the world.

The Medical Society of New Jersey during the last 50 years, a period in which I was myself actively associated with the work of the American Medical Association, has indicated the great part that New Jersey plays in medical organization in the United States. For many years the association met at least once every two years in Atlantic City and a member of the New Jersey Medical Society was always a member of the Board of Trustees of the American Medical Association. One need only recall the services of Philip Marvel and David Allman in this regard. Occasionally a delegate from New Jersey has risen in the House of Delegates to plead some special cause, but in the continued progress of the American Medical Association, New Jersey delegates have always played a conspicuous part. The election of Dr. David Allman as president of the American Medical Association was a recognition of New Jersey's contribution. With the growth of suitable meeting places in other cities in the United States, New Jersey continues to hold a place as a center for the meeting of the American Medical Association at least once every four years.

The great names in New Jersey medicine have been many — so many, indeed, that it would be invidious to choose just a few. I cannot, however, pass this topic without mentioning such names as those of Wells P. Eagleton, Harrison Martland, and Henry Kessler as men of great distinction.

May I then congratulate this great medical society on having achieved 200 years of magnificent service in medicine — a record of distinction for activity and longevity.

5454 South Shore Drive

Chairmen of Councils and Committees 1966-67

Air Pollution Control	Roslyn Barbash, M.D., Teaneck
Annual Meeting	Jerome G. Kaufman, M.D., Maplewood
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A Scientific Appraisal

The Medical Society of New Jersey

James Z. Appel, M.D.*
Lancaster, Pennsylvania



It is certainly a pleasure to be with you this afternoon, not only because I enjoy the fellowship and hospitality of my many friends here in New Jersey, but also because it is a privilege for me to be given the honor of helping you celebrate your 200th birthday.

With so many distinguished and learned representatives on hand from the fields of education, government, industry, religion, and the medical profession, I am confident that this week's activities in Atlantic City will make their effects felt throughout the State of New Jersey during and after this anniversary year of The Medical Society of New Jersey.

In its two centuries of service, The Medical Society of New Jersey has made many significant contributions to the betterment and improvement of the health care of the people, not only of the State of New Jersey but also the people of the entire nation and of the world.

Your society has recognized, however, that its job is never done and that as old problems are solved new ones arise to take their place. Many of these problems, of course, are not limited to or restricted by the boundaries of the New Jersey state line.

During this span of two centuries, the practice of medicine has changed to such an extent that should your founders be able to return to this world today they would not be able to recognize the way we practice nor the diseases we treat. The reliance they placed on natural herbs and crude (as we call them) technics such as cupping and bleeding is no longer condoned. The marked advance in pharmaceutical research has been so great and has accelerated at an ever-increasing rate of acceleration that of the drugs I used 30 years ago when I graduated from medical school, only a mere handful are being used today. The surgical and diagnostic technics that are considered routine and commonplace have developed at an equal rate. The sophistication of many procedures and necessary equipment is such that the physician alone cannot utilize them without help from other disciplines, and actually does not fully understand their workings.

Gone from the scene of diagnosis and therapy are practically all the infectious diseases. In this country very few physicians have ever seen or will ever see a case of smallpox, diphtheria, cholera, yellow fever—all scourges that swept through our peoples at the time of your founding. Measles, mumps, scarlet fever, mastoiditis, pneumonia, tuberculosis are all pretty well controlled, so that they are no longer feared. Our success in these areas has

* Dr. Appel is President of the American Medical Association.

in some cases made us a little careless — both physician and patient. Thus we are presently witnessing an uprise in the incidence of some infections which we have the knowledge to be able to eradicate, but have either not considered as a diagnostic possibility or have treated lightly, such as venereal disease and tuberculosis.

But these great advances have had a further effect on Medicine and how it must be practiced. People live longer. Instead of dying in their younger years of an acute infection they now live to the ages when entirely different types of diseases confront us. Cancer, heart disease, arthritis, mental disorders, and the like are now our major scourges. Congenital defects and acute trauma are demanding solutions that must be found.

These advances are changing the focus of medicine. Likewise the changes that have taken place in society have presented us with new areas in which we must serve. Industrialization has produced urbanization. In 1950 less than 85 million people lived in 168 metropolitan areas. Ten years later, in 1960, 113 million people (63% of the population) lived in 212 metropolitan areas. This is an increase of 32% of the population in a ten-year period, which is almost twice the rate of the national growth. Urbanization, close living, the hustle and bustle of the industrial and business life of the people create new disorders in the individual and new health hazards for the people as a society. Emotional disorders, accidents, food and water supply, industrial and human waste disposal, air contamination are only a few of the by-products of the modern way of life.

Thus, medicine today must direct its attention to preventive medicine, predictive medicine, community health services, public health and environmental control. Because we are confronted by an older population which has developed the degenerative diseases mentioned earlier, we must be able to recognize their development earlier, we must learn to predict their inevitableness in some patients and institute preventive therapy at a time when it is most effective — before the irreversible changes take place that make effective therapy impossible.

How has all this come about? The dedication to humanitarianism and service of our forefathers motivated them to inculcate into the medical code principles of self-improvement. Perhaps the greatest advance forward came with the development of high standards of medical education and ethics which resulted from, and was the reason for, the organization of the AMA. Good education breeds thirst for knowledge and thirst for knowledge to many mandates research.

Research as our forefathers knew it was slow, hazardous for the patients, and depended upon clinical observation by an enlightened physician of his patients during his practicing years. The reading of case-records of one's confreres and one's predecessors was the principal medical literature outside of didactic lectures of professors of medical schools, such as they were.

But these primitive medical research efforts of our founders, frustrating as they must have been, have ballooned out to a tremendous program that today digests each year over one billion dollars. This sum is so fantastic and so in demand as a result of the insatiable thirst for more knowledge — for more answers — that the private economy can no longer completely support it. Approximately 50% of these monies come from the Federal government. The rest comes from private sources, such as private individuals, foundations, and the major portion of this remainder from the pharmaceutical industry itself.

With longer life and an actively productive research program, our generation is faced with a two-fold revolution, a revolution whose repercussions and effects are destined to leave their mark on civilization.

The two developments to which I refer are the *population explosion* and the *knowledge explosion*. These developments are having a profound effect not only on the practice of

medicine, but also on the content and extent of the medical education process that precedes it.

It has been said that 90% of the scientists who have lived and worked in the course of human history on this planet are alive and working today. It has further been said that more medical knowledge has accrued in the past thirty years than in all of previously recorded history.

Recent graduates of our medical schools have learned far more than their predecessors did. The volume of knowledge expected of these graduates was increased to meet the amount of knowledge required to practice good medicine in this decade. The extent of this knowledge also increases continually. Already it has exceeded that which was taught and learned by medical students as recently as ten years ago. Thus, a graduate of that period, unless he has continued his education since graduation, would be woefully out of date today and might well be considered incompetent.

Great strides have been made in adding to the store of medical knowledge. Similar strides have not been made in adding to the store of knowledge that would advance the science of learning itself. But finally we are beginning to see a breakthrough in the science of education.

One such interesting development in education — the use of programmed instruction — has been reported on lately. Though the application of this technic to medical instruction still is at the beginning stage, the initial attempts have been encouraging and indicate that some medical subjects can be programmed.

One method of using the computer as a teaching machine has come to be known as "the medical diagnosis game." The computer leads the blossoming physician by furnishing him with clues and subtle advice to establish a diagnosis for a hypothetical problem.

I believe that these various sophisticated electronic devices must be given a role in the medical education process. Such a development could have two beneficial effects. It would acquaint the medical student with the tremendous potentialities of such equipment; and it might even help to alleviate the ever-increasing burden being placed on our medical educators and medical schools to train more physicians.

That we must train more physicians few would deny. World population doubled between 1850 and 1925 — from 1 billion to 2 billion. By 1980, if the current rate continues, it will have doubled again to 4 billion human beings. Presently, it is 3 billion, but the rate of acceleration itself is constantly accelerating. Therefore, we can anticipate a 6 billion world population by the year 2000. The population of the USA is presently estimated at over 190 million and is increasing about 3 million each year. By the time all senior medical school students graduate this June, there will be 300,000 M.D.'s in this nation.

The physician-population ratio is now below the 1-physician to 700-people mark. I do not presume to know the ideal ratio at which we should aim, but I am sure we will need more physicians than we are presently producing if we are to meet the increasingly demanding health needs of an increasing population. We must provide more educational facilities and devise new technics — push-button technics, if you will — to the fundamental process of medical education itself if we want to keep pace with the population explosion demand and the knowledge explosion.

As more and more information pours out of the research laboratories and medical centers, it becomes increasingly obvious that a medical education never can be considered to have been completed. It is estimated that four times as much is known now as was known in 1935, and in the next 15 years it is believed that scientists will learn as much more as in all previous history. There have been as many scientific papers published since 1950 as in all previous centuries.

But quite unlike Truth or Beauty, Knowledge is not an end in itself. It is the application of this knowledge to specific cases that is the end and the goal of our medical research efforts. The problem is, however, how can we make all the information contained in the many books and scientific papers and reports available to researchers when they need it?

The library's standard abstracting and bibliographic systems are no longer satisfactory solutions in dealing with expanding literature. Years ago, the author H. G. Wells proposed the development of the "World Brain" to record the seemingly endless flow of new knowledge and to retrieve it instantly for inquiring scientists. What seemed to be a science-fiction dream at that time might now become a down-to-earth reality. If the computer, with its great advantages of speed, memory capacity, and ability to follow complex routines, was programmed to store this information and to divulge it on demand, it would be a great step forward for the entire profession.

Actually, something along these lines already is in the planning stage. The Frederick A. Countway Library of Medicine, dedicated in 1965 in a new building next door to the Harvard Medical School, is probably the largest library ever centered in an American university. In this country, the National Library of Medicine is the only comparable institution which is larger. Officials at the Countway Library envision a time when their facilities will be linked by telephone cable with computers at both Yale and Columbia Universities as well as the National Library. Such an inter-connected system would comprise an electric union catalogue that would provide researchers with a rapid interchange of references among the four institutions.

Since computers do have this capability to "talk" to other computers as a result of machine-to-machine hook-ups, another possibility is the development of a nationwide — indeed a worldwide through Telstar — communications network which would bring the medical literature of the world within easy reach of every researcher and physician in the country. Such an electronic network would do much to help the practicing physicians keep up with the ever-changing developments, and to put into use the latest medical technics and practices much sooner than now is possible.

The rapid development and use of instrumentation in the practice of medicine in recent years is really amazing. Today we already have electronic equipment for biochemical laboratory analysis, automatic blood-cell counting, densitometry, and even automatic mass screening for abnormal cells, in specimens obtained from body cavities.

Medical institutions have been rather quick to use computers. They have become a *must* for any large research center. They are being used to transmit and read electrocardiograms on heart patients in VA hospitals in the New England and Boston area. They plot hearing disorders at the University of Pittsburgh. They analyze cardiovascular function at the Latter Day Saints Hospital in Salt Lake City. And they study enzyme kinetics at the Mayo Clinic in Rochester. Remote auditing of critically ill patients in intensive care units of hospitals is becoming quite common. Technics have been developed which enable the radiologist to manipulate x-rays by using computers. Instrumentation in the form of defibrillators, cardiac arrest resuscitators, and cardiac pacemakers is well established. Research in areas of mechanical organs is going on constantly.

But instrumentation and use of computers are only a phase of the tremendous advances we are witnessing today. Molecular research, refinements of intracellular chemistry, and physiology and their significance in cancer and mental dysfunction are appearing every day.

I hope that the emphasis given to computers does not give you the impression that we must look forward to the day when sophisticated instruments will supplant the physician or the

educator. No amount of scientific knowledge, none of the elaborate laboratory procedures and instruments, by themselves, can do what a good physician can do.

The practice of medicine is an art as well as a science. In the days of the founders of this great Medical Society of New Jersey, the art of medicine constituted the major technic available in arriving at a diagnosis and in formulating a course of treatment. It was quite successful, despite its limitations, and made giants of our predecessors. But today, in the rush to gain scientific knowledge and to apply it, in the continual increase in the number of patients physicians are called on to treat, some physicians overlook this technic in their medical practice.

In essence, the art of medicine depends for its successful application on a thorough knowledge of the patient as an individual human being as well as of the scientific aspects of medicine. It requires understanding of the patient's personality, his background, his environment, and his emotional makeup. It necessitates complete knowledge of his character, of the pressures to which he is subjected, and of his reactions to these pressures. The art of medicine is the logical application and interpretation of scientific technics and knowledge to the individual patient as a person.

Thus, the focal point of the physician's activities will continue to be the patient — a human being with a problem who comes to another human being with the hope of finding a solution, just as did the patients of 200 years ago.

305 North Duke Street

OFFICIAL BICENTENNIAL SOUVENIRS



Wall plaque, 8 inches in diameter, gun-stock wood; ceramic insert, 3½ inches in diameter, with MSNJ bicentennial seal in 4 colors. $4 each.



Salad plate, 8 inches in diameter, white porcelain trimmed in gold, with MSNJ bicentennial seal in 4 colors. $3 each or 2 for $5.

Sold by the Woman's Auxiliary to The Medical Society of New Jersey for the benefit of MSNJ's Medical Student Loan Fund. Orders may be sent to the State Auxiliary Office, P. O. Box 904, Trenton, New Jersey 08605.





President John J. Bedrick of Bayonne declares the 200th Annual Meeting in session.



Rabbi Morris M. Tosk of Temple Beth Am, Bayonne, gives the invocation at the opening session.

Dr. Jesse McCall of Newton presides as Speaker of the House.



Everyone is present and accounted for at the first session of the House. Seated on the platform (L. to R.): Dr. Daniel F. Featherston, Treasurer, Asbury Park; Dr. John F. Kustrup, Second Vice-president, Trenton; Dr. Louis K. Collins, First Vice-president, Glassboro; Dr. Joseph R. Jehl, President-elect, Clifton; Dr. Marcus H. Greifinger, Secretary, Newark; Robert M. Backes, Parliamentarian; Dr. Bedrick; Dr. McCall.





Registration begins.



In behalf of AMA-ERF, President Bedrick presents a check in the amount of $565.00 to Dr. DeWitt Stetten, Jr., Dean of Rutgers —The State University.



President Bedrick presents an AMA-ERF check in the amount of $5,800.69 to Joseph F. Salerno of the New Jersey College of Medicine and Dentistry.



President Bedrick presents to Dr. Stewart Alexander, Second Vice-president of the Academy of Medicine of New Jersey, a check in the amount of $8,660.00—representing that portion of the Society's special assessment voted to the Academy by the 1965 House.



The Board of Trustees interrupts one of its meetings in Atlantic City. (L. to R.): Seated: Dr. Emanuel M. Satulsky, Board secretary, Elizabeth; Dr. Thomas C. DeCecio, Cliffside Park; Dr. Charles H. Calvin, Perth Amboy; Dr. Nicholas A. Bertha, Board chairman, Wharton; Dr. Bedrick; Richard I. Nevin, Executive Director; Robert M. Backes, Legal Counsel; Dr. Joseph R. Jehl, President-elect, Clifton; Dr. Daniel F. Featherston, Treasurer, Asbury Park. Standing: Dr. George E. Barbour, Somerville; Dr. Marcus H. Greifinger, Secretary, Newark; Dr. John F. Kustrup, Second Vice-President, Trenton; Dr. Louis K. Collins, Second Vice-president, Glassboro; Dr. Joseph P. Donnelly, Jersey City; Dr. Louis F. Albright, Spring Lake; Dr. Guy A. Campo, Westville; Dr. Nicholas E. Marchione, Vineland; Dr. Frank J. Hughes, Gloucester; Dr. Samuel J. Lloyd, Trenton. Absent was Dr. Jerome G. Kaufman of Maplewood.

MSNJ honors those component societies celebrating their Sesquicentennial anniversaries



Cumberland County plaque accepted by Dr. Mary Bacon of Bridgeton.



Middlesex County plaque accepted by Dr. William G. Kuhn, Jr., New Brunswick, county president.



Monmouth County plaque accepted by Dr. Anthony L. Rifici of Asbury Park, county president.



Morris County plaque accepted by Dr. Raymond C. Maronpot of Bernardsville, county president.



Somerset County plaque accepted by Dr. William F. Jones of Somerville, county president.



Essex County plaque accepted by Dr. Robert E. Fullilove, Jr. of Newark, county president.

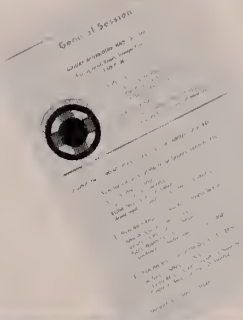
MSNJ staff takes a breather from convention demands to smile at the cemera. (L. to R.): Seated: Robert H. Lambert, Office Manager; Robert M. Backes, Legal Counsel; Mrs. Marion R. Walton, Administrative Assistant—Assistant Convention Manager; Richard I. Nevin, Executive Director; Theresa E. Goeke, Executive Assistant—Assistant Editor of THE JOURNAL; Dr. Henry A. Davidson, Editor of THE JOURNAL. Standing: Matthew Squreck, Clerk-Machine Operator; E. Powers Mincher, Legislative Analyst: Mrs. Addie P. Holden, Clerk-Typist; Eileen M. Pfeiffer, Clerk-Typist; Mrs. Phyllis N. Chrismer, Clerk-Typist; Diana Pleva, Stenographer; Mary Mike, Clerk-Typist; Mrs. Lois C. Stump, Stenographer. Absent: Mrs. Edith L. Madden, Administrative Secretary-Convention Manager; Mrs. Shirley M. Walsh, Auxiliary Secretary; Mrs. Brenda Cento, Receptionist-Typist; Mrs. Sandra Handwerk, Stenographer.



References Committee "A": (L. to R.): Dr. Adolph R. Wichman, Denville; Dr. Robert G. Steinman, Cape May Court House; Dr. Henry J. Mineur, chairman, Cranford; Dr. William J. D'Elia, Neptune City; Dr. Charles L. Cunniff, Jersey City.







General Session on Medicare panelists: (L. to R.): William C. White, Jr., Prudential Insurance Company of America, Newark; John W. Cashman, M.D., Chief of the Division of Medical Care Administration, Department of HEW, Washington, D. C.; Dr. Ernest B. Howard, Assistant Executive Vice-President, AMA, Chicago, Illinois; Arthur E. Hess, Director of the Bureau of Health Insurance, Social Security Administration, Department of HEW, Baltimore, Maryland.



Reference Committee "F": (L. to R.): Dr. Rudolph T. DePersia, Woodbury; Dr. Walter E. Corrigan, Toms River; Dr. Robert E. Verdon, chairman, Cliffside Park; Dr. Charles Cunningham, Vineland.



The House of Delegates meets for the second (election) session.

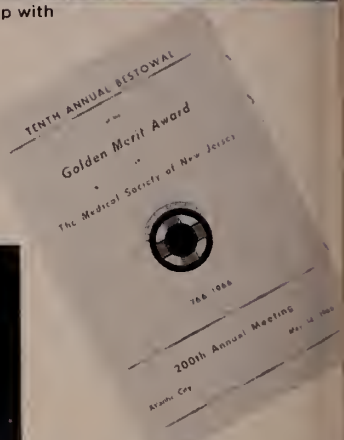




1. Golden Merit Award recipients line up with their county society presidents.



2. (L. to R.): President Bedrick; Dr. Mary Bacon, Bridgeton; her husband, J. Irving Caruthers; Dr. Jesse W. Carll, Cumberland County president.





3. (L. to R.): President Bedrick; Dr. Samuel S. Butler, Ocean City; Dr. Thomas H. McGlade, Camden County president.







5. (L. to R.): Seated: Dr. Arthur G. Pilch, West Boothbay Harbor, Maine; Dr. Joseph W. Gardam, Newark; Dr. Nathan B. Heller, East Orange; Dr. Francis J. McCauley, Newark. Standing: Dr. Maurice Cohen, Montclair; Dr. Robert E. Fullilove, Jr., Essex County president; Dr. Leon J. Camche, Newark.



7. (L. to R.): Seated: Dr. Thomas M. Morris, Plainfield; Dr. Merton L. Griswold, Jr., Union County President; Dr. Rocco M. Nittoli, Elizabeth. Standing: Dr. Elbert H. Pogue, Elizabeth; Dr. Emanuel M. Satulsky, Elizabeth; Dr. Manuel J. Rowen, Elizabeth; Dr. Anthony J. Bruno, Elizabeth.



4. (L. to R.): President Bedrick; Dr. James N. Coombs, Ocean City; Dr. Carl N. Ware, past-president of the Cape May County Medical Society.

6. (L. to R.): Seated: Dr. Sidney C. Levine, Paterson; Dr. Louis Lipton, Passaic; Dr. Harold M. Stein, Paterson. Standing: Dr. Irving R. Hayman, Passaic County president.

8. (L. to R.): Seated: Dr. Miles T. Long, Jersey City; Dr. John V. Kearney, North Bergen; Dr. Sophia L. Halpern, Union City; Dr. John A. Botti, Jersey City. Standing: Dr. Charles L. Cunniff, Hudson County president.



The audience rises to welcome . . .



Richard J. Hughes, Governor of New Jersey, with President Bedrick.



Governor Hughes stops to greet Dr. Joseph A. Lepree of Elizabeth.



Bicentennial General Assembly panelists: (L. to R.): Dr. Morris Fishbein, Chicago, Illinois; Governor Hughes, President Bedrick; Dr. James Z. Appel, AMA President, Lancaster, Pa.



The panelists get down to work. (L. to R.): Dr. Appel, Dr. Fishbein, Governor Hughes, President Bedrick.

MSNJ welcomes into Honorary membership . . .



Selman A. Waksman, Ph.D., of New Brunswick was cited for "singular and distinguished service to mankind and for outstanding contributions to medical science."



Dr. Dickinson W. Richards of Englewood was cited for "singular and distinguished service to mankind and for outstanding contributions to the science and art of medicine as physician, teacher, lecturer, writer, and research scholar."



Dr. Morris Fishbein of Chicago, Illinois, was cited for "singular and distinguished service to medicine and mankind as physician, teacher, lecturer, writer, and medical statesman."



Dr. Nicholas F. Alfano, Newark, MSP President, presides at the Open Discussion on Medical-Surgical Plan.



Richard I. Nevin of Trenton was acclaimed "for his distinguished and faithful service to the Society as its Executive Director and for his dedication to the highest ideals of MSNJ and to the health and well-being of the people of New Jersey whom the Society serves."



Publication Committee meets in Atlantic City to finalize plans for the Bicentennial issue. (L. to R.): Mr. Nevin, Executive Director; Dr. Frank J. Hughes, Gloucester; Dr. James J. Fitzpatrick, Trenton; Joseph W. Cookson, Local Advertising Representative; Dr. C. Spencer Davison, Salem; Dr. Davidson, JOURNAL Editor, Cedar Grove; Dr. George B. Sharbaugh, Chairman, Trenton; Miss Goeke, JOURNAL Assistant Editor; Dr. Featherston, Dr. Lloyd, Dr. Bedrick, Dr. Jehl.

NEWS RELEASE from
THE MEDICAL SOCIETY OF NEW JERSEY

FOR RELEASE
Upon Receipt
May 1 1966

310 West State Street — Trenton, New Jersey 08618 — Phone 394-3184

Following are [illegible] of the election session [illegible] the Boulder [illegible]

NEWS RELEASE from
THE MEDICAL SOCIETY OF NEW JERSEY

FOR RELEASE
After 1:00 p.m.
Saturday
May 14, 1966

310 West State Street — Trenton, New Jersey 08618 — Phone 394-3184

SUBJECT: REMARKS OF JOHN J. BEDRICK, M.D., President of

NEWS RELEASE from
THE MEDICAL SOCIETY OF NEW JERSEY

FOR RELEASE
After 5:00 p.m.
Saturday
May 14, 1966

310 West State Street — Trenton, New Jersey 08618 — Phone 394-3184

SUBJECT: MEDICENTENNIAL CITATIONS

NEWS RELEASE from
THE MEDICAL SOCIETY OF NEW JERSEY

FOR RELEASE
Upon Receipt

310 West State Street — Trenton, New Jersey 08618 — Phone 394-3184

SUBJECT: 200th ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

The Medical Society of New Jersey will hold its 200th Annual Meeting at Chalfonte-Haddon Hall, Atlantic City, from Saturday, May 14 through Wednesday, May 18. Founded in New Brunswick July 23, 1766, the Society is the oldest medical organization in America. In celebration of its Bicentennial, the Annual Meeting program will offer many outstanding features and will present a distinguished array of dignitaries and medical authorities.

The regular scientific program will consist of eight joint section meetings, in the course of which twenty-six original papers will be presented. A special collection of exhibits dealing with the history of medicine will be shown during the convention, and a total of sixty-five technical exhibits will be offered for professional attention.

Tuesday, May 17, has been set aside as Bicentennial Day. It will feature a special Bicentennial Scientific Session in the morning, consisting of a symposium on gastro-intestinal bleeding. In the afternoon, there will be the Bicentennial General Assembly, in the course of which Governor Richard J. Hughes; Dr. James Z. Appel, AMA President, and Dr. Morris Fishbein, outstanding author, editor, and lecturer, will deal with the theme: "The Medical Society of New Jersey - A Civic, Scientific, and Historical Appraisal."



Bicentennial Scientific Session panelists: (L. to R.): Dr. William S. Blakemore, Philadelphia, Pa.; Dr. John L. Madden, New York, N. Y.; Dr. Henry J. Tumen, Philadelphia, Pa.; President Bedrick.



Members gather for scientific meetings.



Honors come to MSNJ on the occasion of its Bicentennial



Dr. Frederick A. Wurzbach, delegate from the State of New York, presents a plaque to President Bedrick.



In behalf of the New Jersey Academy of General Practice, Dr. Harry P. Goodman, president, presents a citation to President Bedrick.



The Judicial Council meets in Atlantic City for election of officers. (L. to R.): Dr. Thomas S. P. Fitch, Plainfield; Dr. John S. Madara of Salem; Miss Goeke, staff member serving as recorder; Dr. E. Vernon Davis, chairman, Mount Holly; Dr. Albert F. Moriconi, Trenton; Mr. Backes, legal counsel; Dr. John L. Olpp, secretary, Englewood.



President Bedrick accepts a citation from F. Fisher White, member of the Board of Control, State Department of Institutions and Agencies.



Dr. E. Tremain Bradley brings official greetings from the Connecticut State Medical Society.

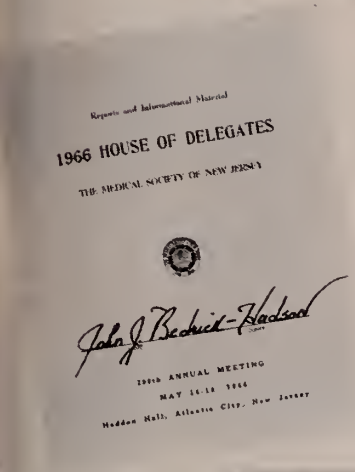


Mrs. Richard A. Sutter, President of the Woman's Auxiliary to the American Medical Association, addresses the House.



In behalf of Parke-Davis, R. F. Davison presents four framed reproductions of the History of Medicine Series.





The third session of the House of Delegates meets in "schoolroom" style.



Dr. Samuel J. Lloyd, Trenton, MSNJ trustee, addresses the House.





MSNJ honors Mrs. Asher Yaguda in recognition of her services as President of the Woman's Auxiliary to the American Medical Association, 1966-67. Dr. Yaguda accepts the citation for his wife.



MSNJ honors Dr. Fred B. Rogers, Trenton, for his services as historian-archivist.

The lighter side . . .



MSNJ fetes the exhibitors at an informal buffet.



Receiving line for President-elect Jehl's reception. (L. to R.): Dr. Jehl; Mrs. Jehl; Mrs. Joyce Jehl Sutherland; Mrs. Richard A. Sutter, AMA Auxiliary President; President Bedrick.



Members and guests gather for Bicentennial Day Luncheon



The Atlantic City Convention Bureau holds a reception in honor of MSNJ's Bicentennial.



(L. to R.): Dr. Morris Fishbein, Mrs. Nicholas A. Bertha, Mrs. Morris Fishbein, Dr. Emil Hornick, Dr. Ralph Hatcher, Mrs. Hatcher, Dr. Bertha, Mrs. Hornick.



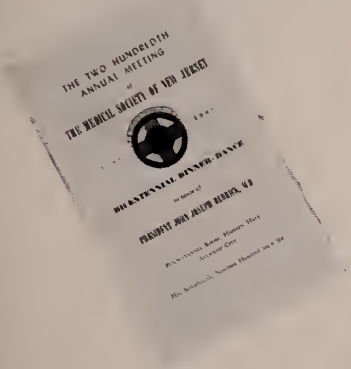
(L. to R.): Mrs. Joseph R. Jehl, President Bedrick, Mrs. Ruth Lockett, Dr. Jehl, Mrs. James Z. Appel, Dr. Appel.



Head Table. (L. to R.): Dr. Charles H. Calvin, immediate Past-president; Mrs. Nicholas A. Bertha; Rev. John E. Furniss, S. G., New York; Mrs. Richard I. Nevin; Mason W. Gross, Ph.D., President, Rutgers—The State University, Dinner Speaker; Mrs. Jesse T. Glazier, incoming President of the Woman's Auxiliary; President Bedrick; Richard I. Nevin, Toastmaster; Mrs. Lewis C. Fritts, retiring President of the Woman's Auxiliary; Mrs. Charles H. Calvin; Dr. Joseph R. Jehl, President-Elect; Mrs. Joseph R. Jehl; Dr. Jesse T. Glazier; Dr. Nicholas A. Bertha, Chairman, MSNJ Board of Trustees.



Dr. Charles H. Calvin, immediate Past-president, presents the Fellow's Key to retiring President Bedrick.



MSNJ Fellows (L. to R.): Dr. and Mrs. Ralph M. L. Buchahan, Phillipsburg; Dr. and Mrs. Louis S. Wegryn, Elizabeth; Dr. and Mrs. Vincent P. Butler, Jersey City.





Toastmaster Richard I. Nevin introduces President Bedrick, in whose honor the dinner was held.



MSNJ Fellows (L. to R.): Dr. and Mrs. Harold A. Murray of Sea Girt; Dr. and Mrs. J. Howard Hornberger of Roebling; Dr. and Mrs. Elton W. Lance of Rahway; Dr. and Mrs. David B. Allman of Atlantic City.



(L. to R.): President Bedrick, Mrs. Lewis C. Fritts, Dr. Joseph R. Jehl, Mrs. Jehl.



Miss Licia Albanese of the Metropolitan Opera charmed the guests with her musical selections after the dinner.



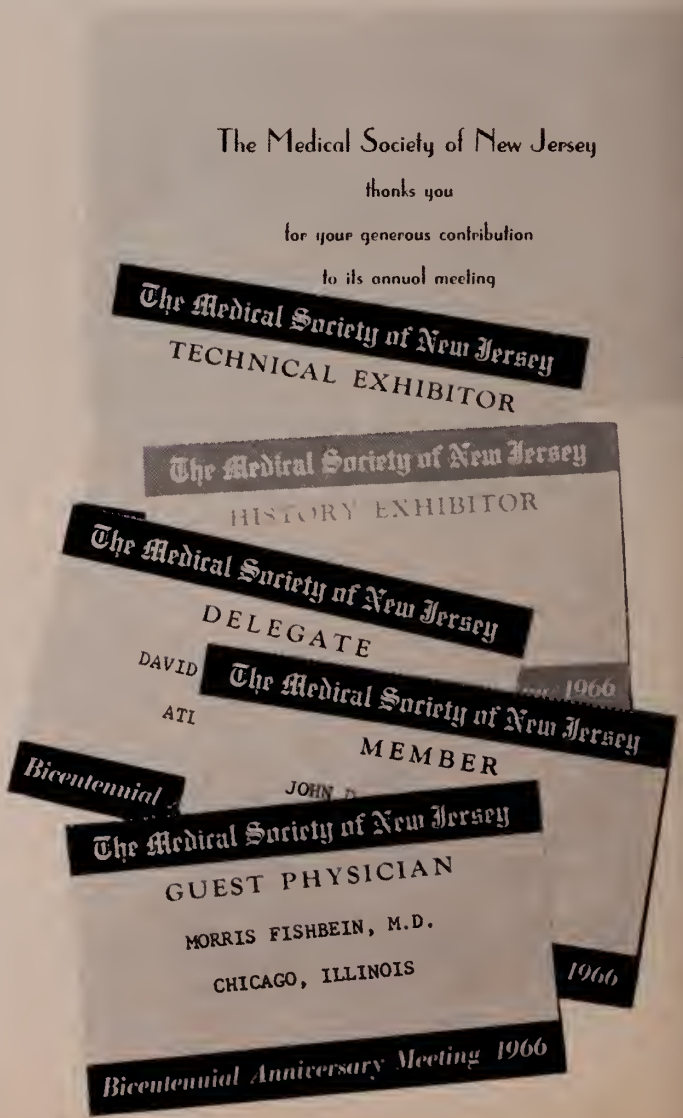
Dr. Jehl's granddaughter shares the sentiments of all at the concluding session: "I'm tired and I want to go home . . ."



Retiring President Bedrick shares the spotlight with MSNJ's new official family. (L. to R.): Dr. Bedrick; Mrs. Joyce Jehl Sutherland and daughter Karen; Incoming President Joseph R. Jehl.



New President Jehl adjourns the 1966 House of Delegates sine die.



MSNJ Woman's Auxiliary holds 39th annual meeting

OFFICIAL PROGRAM

39th Annual Meeting

Woman's Auxiliary

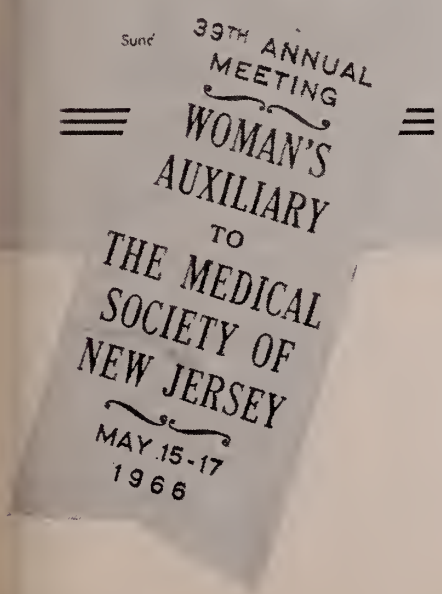
to

The Medical Society of New Jersey

Chalfonte-Haddon Hall
Atlantic City

1927 1966







President's Luncheon. (L. to R.): Dr. John J. Bedrick MSNJ President, Mrs. Richard A. Sutter, President, Woman's Auxiliary to the AMA; Richard I. Nevin, Executive Director, MSNJ; Mrs. Lewis C. Fritts, President, Woman's Auxiliary to MSNJ; Mrs. John F. Kustrup, Second Vice-President; Mrs. Samuel Kaman, Convention Chairman; Dr. George O. Rowohlt, Chairman, MSNJ's Woman's Auxiliary Advisory Committee.



Auxiliary State Officers 1966-1967. (L. to R.): Mrs. John VanMater, Treasurer, Highland Park; Mrs. Sydney G. Fine, Recording Secretary, Titusville; Mrs. John F. Kustrup, First Vice-President, Trenton; Mrs. David Zuckerman, President-elect. Paterson; Mrs. Jesse T. Glazier, President, South Orange; Mrs. Edward O. MacDonald, Second Vice-president, Westfield; Mrs. James Spillane, Corresponding Secretary, Phillipsburg; Mrs. Rufus R. Little, Director, Paramus.



1966-1967 County Presidents' Briefing Breakfast. (L. to R.): Seated: Mrs. Richard C. Drewes, Mercer; Mrs. Louis Abbamonte, Essex; Mrs. N. Maurice Re, Bergen; Mrs. David E. Zuckerman, State President-elect Mrs. Orest M. Pawluk, Burlington; Mrs. Thomas Connolly, President-elect, Hudson; Mrs. John Holdcraft, Gloucester; Mrs. John Scillieri, Passaic; Mrs. Jesse T. Glazier, State President; Mrs. Joseph Camarda, Ocean; Mrs. Elmer L. Grimes, Camden; Mrs. Frank Pflum, Monmouth; Mrs. George Hatcher, Morris; Mrs. Loring Sylvester, Salem; Mrs. Victor Boogdanian, Middlesex; Mrs. Robert Salasin, Cape May; Mrs. Frank A. Wolf, Jr., Warren; Mrs. Levi Walker, Atlantic.

BICENTENNIAL SCIENTIFIC SESSION

Surgical Approach to Gastrointestinal Bleeding: Esophageal Bleeding in Varices and Hiatal Hernia*

Symposium on Gastrointestinal Bleeding

William S. Blakemore, M.D.
Moreye Nusbaum, M.D.
Arthur E. Baue, M.D.

Philadelphia, Pa.

Slow but encouraging progress continues in the treatment of bleeding from esophageal varices. The basic problem of portal hypertension remains unsolved but as surgical technics improve, new operative procedures are being evaluated. Vigorous discussion and controversy about different methods of treatment reflects over-all disappointment with the results in patients with severe hepatic disease. With esophageal varices and repeated hemorrhages, the mortality is primarily related to whether the disease is due to extrahepatic portal block with good hepatocellular function or to intrahepatic disease with poor liver function. Studies reported between 1942 and 1962 (of more than 1,000 patients with cirrhosis and bleeding varices) show a mortality range of 40 to 80 per cent with a mean of 65 per cent. Mortality rises progressively with each hemorrhage.[1] In contrast, mortality is low in patients with good hepatocellular function and operative procedures can be delayed. The statistics from different centers are not always comparable because of the small number of patients in each series and because the reports include therapeutic regimens that are constantly changing as the investigators seek to improve the treatment.

In patients observed during the early period following admission for massive upper gastrointestinal hemorrhage, there is often some doubt concerning the site of bleeding. A previous diagnosis of cirrhosis suggests bleeding esophageal varices. However, the association of bleeding from a duodenal ulcer in patients with cirrhosis significantly complicates the problem. Among the items of information available to the clinician are those obtained by a meticulous physical examination; the presence of collateral venous circulation, spider angiomata, petechiae, hepatosplenomegaly, or ascites. Laboratory studies in general have not been helpful in the patient with acute massive bleeding. Studies of liver function and coagulation defects may be useful in selected patients but are not universally reliable or available. The blood ammonia level does give an indication of portal-systemic

* Read at the Bicentennial Session of The Medical Society of New Jersey in Atlantic City, May 17, 1966.

From the Division of Graduate Medicine, the Harrison Department of Surgical Research of the School of Medicine, and the Graduate Hospital of the University of Pennsylvania, Philadelphia.

Dr. Blakemore is Chairman of the Department. Dr. Baue is Assistant Professor of Surgery at the Graduate Division and Dr. Nusbaum is an Associate in Surgery there.

shunting of blood but does not identify a bleeding source. The acceptability of splenoportography varies among surgeons. Mortality and morbidity are related to the experience with this method. Meticulous technics must be utilized. The amount of hemorrhage after the procedure is also related to the elevation of splenic pulp pressure. Experience in our hospital has proved splenoportography to be of value, but its use is limited to a few experienced members of the radiologic and surgical staffs.

Recently selective celiac axis arteriography has proved to be helpful. In the hands of physicians experienced in the technic it involves little risk. It provides an additional advantage in that bleeding from sources other than varices can be demonstrated anatomically with this procedure. If the portal pressure is elevated, the portal vein is not as well visualized as in normal individuals but the collateral circulation and varices are usually demonstrated. The characteristic arterial pattern of the cirrhotic liver complements the information gained by observation of the collateral venous circulation. Anatomic demonstration of the site of bleeding by selective arteriography has been of assistance to the surgeon in a sufficient number of instances so that this procedure is now done routinely on our service in patients with massive upper gastrointestinal bleeding.[2]

Coagulation defects frequently add to the difficulty in management of these patients. Thrombocytopenia associated with hypersplenism occurs and this is compounded by transfusion of stored bank blood which does not permit survival of platelets. Fibrinolysins are also frequently reported to be present. Freshly drawn, carefully prepared blood appears to be the best therapeutic agent for correction of these defects. Consideration should be given to including fresh transfusions in the initial treatment of these patients.

Treatment begins with the control of bleeding if massive. This is best done by the use of balloon tamponade with a Sengstaken-Blakemore tube or a Linton tube and, more recently, gastric cooling utilizing a preshaped esophageal balloon. Results of esophageal balloon tamponade in bleeding cirrhotic patients, again compiled from the statistics of reported cases, indicate that initial control can be obtained in about 68 per cent of the patients, though ultimate control is obtained in only half this many. Mortality in patients treated by balloon tamponade alone is high; it approaches 74 per cent. Problems related to esophageal tamponade are well recognized and care should be taken to avoid these complications whenever the program is used. We utilize gastroesophageal cooling using a preshaped balloon in which uniformly initial control of the bleeding from esophageal varices has been obtained. There is a lower incidence of complications than with tamponade since forceful upward tension on the tube is not required and ulceration of the nose or expulsion of the tube in the nasopharynx is avoided. The aspiration of secretions in these patients, who are often partly comatose, requires vigorous care. Occasionally tracheostomy is required to control the pulmonary complications. While the cooling procedure provides initial control, more than 50 per cent of these patients hemorrhaged again within 48 hours. Thus, further measures must be considered while the period of cooling is being used to treat the patient and provide more stable conditions for definitive procedures.

After initial control of bleeding (or if bleeding stops spontaneously) consideration of operative treatment is given to a selected group of patients who are less than 50 years of age, free from hepatic encephalopathy, without ascites or elevation of serum ammonia and total bilirubin, have a serum albumin greater than 3 grams per cent and a prothrombin time corrected within normal limits. These patients are usually candidates for immediate portacaval shunting procedures. It is of importance fully to restore the blood volume in these patients before anesthesia is induced. Most patients do not meet these qualifications of the "good risk" patient and other procedures are better considered.

Transesophageal ligation has a reported mortality of between 15 and 86 per cent with a mean of 35 per cent. The operative approach can be either transthoracic or transabdominal. Hypothermia may be a useful adjunct to protect the liver against further damage during the operative procedure. The anesthetic agents selected should be those which are least likely to interfere with hepatic function. Additional consideration should be given to doing a portacaval anastomosis following control of the hemorrhage. Once a shunt is successfully made, the incidence of subsequent hemorrhage is less and with the progressive character of the liver disease more frequently recognized, vigorous treatment should be instituted. Whether these patients will survive longer is not known with the information now available, but they are not likely to die from repeated hemorrhages from their varices if an adequate shunting procedure has been performed. In children, portacaval anastomosis is delayed until the second decade of life and a splenorenal shunt may be substituted. Some patients remain too poor a risk for this operative procedure. These patients often have a number of the following findings: over 65 years of age, intractable ascites, hepatic encephalopathy, elevated serum ammonia and bilirubin, sulfobromophthalein retention over 30 per cent, serum albumin less than 2 grams per cent, and a low prothrombin time that does not respond to treatment. Almost all new operative procedures are given consideration for this group of unfortunate patients. More recently, stimulated by the discouraging results of treatment in this group of patients, we are exploring a technic of percutaneous catheterization of the superior mesenteric artery which permits the infusion of surgical Pituitrin directly into this vascular bed.[3] Utilizing animals, with acute obstruction of the hepatic portal bed to obtain elevation of the portal pressure, the portal hypertension could be relieved by sufficiently small amounts of the drug so that cardiac output and systemic blood pressure were not depressed. The superior mesenteric artery flow was decreased and this procedure might well be utilized further in the treatment of patients.

Hiatal Hernia

The problems related to hemorrhage in patients with a hiatal hernia are again often complicated by the difficulty in determining the site of bleeding. A significant number of patients have sudden gastrointestinal hemorrhage associated with a sliding hiatal hernia. This may be from esophagitis or from ulceration in the herniated stomach. In these patients, in contrast to those with bleeding from esophageal varices, esophagoscopy often is a helpful diagnostic procedure, and the recognition of esophagitis in association with a hiatal hernia is a factor in the choice of surgical repair in the treatment of these patients. The use of the string test is another helpful diagnostic technic of localizing the site of bleeding, along with radiographic confirmation. Gastric ulcer in a hiatal hernia can frequently be found by barium meal. In more than 95 per cent of the patients, the site of bleeding can be localized if time permits diagnostic study. Erosive esophagitis or gastritis and gastric ulcer are often the cause of bleeding. Care must be taken not to overlook a duodenal or gastric ulcer as the cause of bleeding with an incidental hiatal hernia which is asymptomatic and present in 55 per cent of the normal population.[4] Other lesions of the gastrointestinal tract should be similarly excluded. In the selection of treatment for these patients, standard technics for the repair of the hernia should be considered.[5] These include closure of the posterior portion of the hiatus, esophagogastropexy, and in patients with esophagitis and high gastric acidity, vagotomy and pyloroplasty or antrectomy might similarly be considered along with gastropexy. Gastropexy and plication of the gastric fundus are also effective technics for reducing the hernia. In patients too ill for consideration of other procedures, left phrenic nerve crush for the control of hematemesis should be considered, particularly if the hiatal hernia is incarcerated. We consider the use of this method in the elderly patient where the pulmonary reserve permits the consideration of the loss of the motion of the left diaphragm. The physiological alterations involved in hiatal hernia have been studied[6,7] and the purpose of the surgical

repair should be to reduce the hernia and keep it reduced and restore competence of the gastroesophageal sphincter to present reflux of gastric contents.

The Mallory-Weiss Syndrome

This is not an infrequent cause of severe and persistent upper gastrointestinal hemorrhage and may easily be overlooked.[8] Bleeding from lacerations of the cardia of the stomach and lower esophagus as a result of prolonged or forceful vomiting was originally described by Mallory and Weiss in 1929.[9] This sequence of events has occurred most often in alcoholics and elderly individuals with gastritis but may develop in anyone with vomiting or retching. The episode of vomiting producing such a laceration may be forgotten by the patient when it is followed by hematemesis. Such lesions are not common but are extremely important because they can be treated satisfactorily when this problem is considered or suspected. The diagnosis can be made only by a high index of suspicion on clinical grounds and by operation. Esophagoscopy has not shown the lesions, nor has gastroscopy or barium swallow. Treatment consists in suture of the longitudinal tears through a liberal gastrotomy. Mobilization of the stomach or esophagus is not necessary. Traction on the nasogastric tube through the cardia will facilitate its exposure. In a patient with upper gastrointestinal hemorrhage that necessitates operation, the cardia must be adequately inspected before undertaking a blind procedure or stopping the search for bleeding. It is suspected that this problem occurs more frequently than has been reported. Laparotomy and gastrotomy may not reveal these lesions unless one specifically looks for them.

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University of Pennsylvania

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Medical Approach to Upper Gastrointestinal Bleeding*

Symposium on Gastrointestinal Bleeding

Henry J. Tumen, M.D./Philadelphia, Pa.

Massive bleeding from the upper gastrointestinal tract is often a most challenging emergency. The challenge is a multiple one. There is first the diagnostic challenge — the difficulty, often the impossibility, of determining the source of the hemorrhage despite skillful use of all available diagnostic procedures. Then there is the challenge of treatment — the need to evaluate the severity of the hemorrhage and to institute prompt measures to control and counteract it, and the need to plan a course of therapy that will protect against similar catastrophes in the future. In many instances the major therapeutic decisions focus on the question of surgical intervention and the necessity for this, its timing and the preparation of the patient as well as the choice of the procedure. Certainly, there are few situations in which the closely coordinated efforts of internist and surgeon are more desirable. This is recognized by the formulation of a policy in many hospitals engaging both internist and surgeon in the care of a patient with gastrointestinal bleeding right from the moment of admission. These policies are justified by the evidence that the results of treating patients with hemorrhage are best when such a policy prevails.

Causes of Upper Gastrointestinal Bleeding

To list the causes of upper gastrointestinal bleeding and to discuss each cause is a very lengthy process. These hemorrhages have many causes, the majority rather unusual. It is generally agreed, of course, that the outstanding causes are peptic ulcer disease, superficial gastric mucosal lesions that are usually grouped together under the general heading of "gastritis," gastric neoplasms and esophagogastric varices secondary to cirrhosis. This, however, is much too simple a statement. It glosses over certain inaccuracies and seems to accept as facts opinions that are hard to prove. It does not recognize sufficiently the limitations of our diagnostic tools or that these often fail to give the information needed. The clinical features, radiologic and endoscopic examinations and even the operative findings or the pathologist's study may not define exactly the source of a hemorrhage. This is particularly true in the case of acute mucosal lesions that heal quite rapidly after having bled so that investigation even a few days later may reveal nothing. All too often, however, it is assumed that there was a peptic ulcer that caused the hemorrhage. As an example, Avery Jones[1] reported on 1,910 patients admitted with hematemesis and melena. He stated that in 1764, or 90 per cent of these, the cause of bleeding was "proved or probable peptic ulcer." Definite chronic, gastric or duodenal ulcers, however, were found in only 965, or 50 per cent, of the patients. 559, or about 30 percent, were reported to have "acute lesions," but in only 167 of these, about 8 per cent of the total, was there definite and acceptable evidence of ulcer. Therefore, in this series only about 58 per cent rather than 90 per cent of the patients had proved ulcer disease and in the remaining 32 per cent the existence of ulcer could be only presumed. As long ago as 1830 Abercrombie[2] commented on this diagnostic dilemma. He wrote concerning massive hemorrhage, "This which we have seen as a result of ulceration, also occurs without such disease. I have seen it fatal when no organic

*Presented at the Bicentennial Meeting of The Medical Society of New Jersey, Atlantic City, May 17, 1966.

disease could be discovered and even the source of the hemorrhage could not be detected."

The nature of the acutely bleeding gastric ulcers is often hard to determine. They range from true peptic ulcers that are relatively shallow and heal rapidly to "gastritis" and "erosions" and often escape detection unless gastroscopy is done almost immediately following the onset of bleeding. Their causes also vary a great deal and include acute infectious disorders, burns, acute stress, cerebral lesions, and intracranial operations. In recent years we have become aware of the frequency with which mucosal lesions and hemorrhages are caused by drugs — notably the salicylates, steroids, and Butazolidin. The drug-induced gastric lesions causing hemorrhage must now be listed among the most important of the adverse drug reactions and certainly require consideration in all patients admitted with upper gastrointestinal bleeding.

The current opinion, therefore, is that acute mucosal lesions are important and frequent causes of hemorrhage even though their true incidence is difficult to state. It has also become obvious that they are frequently the source of hemorrhage even in patients with more prominent lesions. This is particularly the case in patients with cirrhosis and varices, among whom many are found to bleed, not from varices but from coincidental gastric mucosal lesions, either "gastritis" or superficial ulcers. Such occurrences offer one explanation of the difficulties in formulating hard and fast statistics on the incidence of any single cause of hemorrhage.

Variceal bleeding is, nevertheless, an extremely important problem. Varices are thought to be the source of bleeding in as many as from five to ten per cent of patients with massive hemorrhage studied in larger city hospitals. The incidence varies considerably with the population studied and the type of hospital and, as I have already indicated, it may be difficult to prove that a hemorrhage did come from varices that are easily demonstrated. It must be emphasized, however, that bleeding in a cirrhotic patient is even more of a catastrophe than in others because of the fact that hemorrhage may precipitate coma. Further, hemorrhage from varices calls for specific measures to control it and for a much different type of surgical management than might be used in other types of hemorrhage. For these reasons strenuous effort must be made to recognize cirrhosis as it exists in a bleeding patient and to determine, if possible, whether the bleeding did come from varices.

The recognition of the outstanding frequency of certain causes of bleeding — gastroduodenal ulcer, acute mucosal lesions of the stomach, gastric neoplasm, varices — does not detract from the importance in individual cases of the many less frequent causes of hemorrhage or from the need to consider these in the diagnostic approach. Although each of these cannot be discussed in detail, it is obvious that physicians dealing with the problem of hemorrhage must be familiar with even these rarer causes that include in their diagnostic studies examinations that will exclude or discover such lesions.

Diagnostic Approach

The diagnostic approach to upper gastrointestinal bleeding should be practicable and carried out with facility and in a manner that will not further tax a patient already depleted; informative and directed toward giving necessary and useful data; and as conclusive as possible in determining the actual cause of hemorrhage or, at least, localizing its site and evaluating its severity.

I need not review the information to be gained from such fundamentals as the history — specifically directed toward evidence of previous ulcer disease, the use of ulcerogenic drugs, the recent occurrence of vomiting that might have caused Mallory-Weiss lesions, or a background conducive to cirrhosis — or the physical examination, with search for the stigmata of cirrhosis, the presence of abdominal masses, evidence of blood dyscrasias, etc. Often, however, the information from history and physical examination is not

very helpful. It has been observed that "the circumstances of a shocked patient, anxious relatives and the pressing demands of resuscitation only too often militate against accurate history taking,"[3] and it is probably true that the early clinical diagnostic accuracy in assessing the causes of hemorrhage is only about 60 per cent.[4]

Routine laboratory studies, though of great value when assessing the severity and response to hemorrhage, likewise are of little help in differential diagnosis. The blood count may reveal the features of a blood dyscrasia. Leukocytosis after hemorrhage is more likely to occur with ulcer bleeding than with bleeding from esophageal varices in cirrhosis. Failure of the blood urea nitrogen to rise suggests that bleeding has come from a lower segment of the gastrointestinal tract, but this type of information is a clue rather than a specific diagnostic point. We believe that liver function tests, notably the bromsulphalein test and serum bilirubin determinations, are of value in excluding cirrhosis with varices as a source of bleeding. In general it can be said that if these procedures give normal responses it is extremely unlikely that the patient is bleeding from varices due to cirrhosis. The converse, however, is not true; abnormal liver function tests in a bleeding patient do not prove that varices are the cause of the bleeding.

Since history, physical examination and routine laboratory studies may not be of much diagnostic help we must often turn to other procedures. It is important to know how safe these are and how much assistance they give. In some centers there have been developed programs of intensive, almost "aggressive," early study of patients admitted with severe hemorrhage and these programs often include not only early x-ray examinations but early esophagoscopy and/or gastroscopy, gastric secretory studies and other more complicated techniques. One may question the need for a standard formalized program to be applied in every case. It seems best to be sufficiently skillful in using a variety of methods so that these may be applied selectively whenever they seem likely to give useful information.

Wide experience has now shown that there need be no fear of subjecting patients to x-ray studies of the gastrointestinal tract very soon after hemorrhage, provided he is not actually in shock and provided, of course, that reasonable gentleness and care are used in manipulating the patient. We are convinced that such an examination is not hazardous and that the information gained may be very helpful. Neoplasms, both benign and malignant, are usually readily demonstrated, and early x-ray examinations will visualize about 60 to 70 per cent of chronic gastric and duodenal ulcers that cause massive bleeding. The accuracy of x-rays in demonstrating varices is much less, probably less than 50 per cent. In general, it may be concluded that carefully performed roentgen examinations of the esophagus, stomach and duodenum are reliable in excluding gross lesions of these organs (other than varices) as causes of massive bleeding, and that if no such lesions are demonstrated this lends support to the probability that the bleeding was caused by some type of mucosal erosive disorder.

In recent years the highly specialized roentgen technique of abdominal angiography has been used to localize and to define bleeding upper gastrointestinal lesions. At the Graduate Hospital, Dr. Stanley Baum and his associates have been quite successful in demonstrating bleeding arising from gastroduodenal ulcers, varices, gastric neoplasms and Mallory-Weiss tears, and we have come to rely a great deal upon this diagnostic approach. Abdominal angiography requires special equipment and specifically trained personnel, but it is certainly a valuable and safe procedure when used skillfully and judiciously.

Endoscopic examinations, both esophagoscopy and gastroscopy, are also extensively used in studying bleeding patients and also without undue hazard in skilled hands. Esophagoscopy is the most direct method for detecting varices and for determining whether they are actually bleeding. As an example of this, Conn and

Brodoff[6] reported that esophagoscopy correctly distinguished bleeding varices from other lesions in 91 per cent of the bleeding episodes in which it was carried out.

Similarly, early gastroscopy has proved to be of great utility in studying patients with gastric ulcers, gastric neoplasms and gastric erosions. It is particularly helpful in those patients who bleed from diffuse erosive lesions. The value of gastroscopy depends not only on the skill of the examiner but also upon the time of the examination. So many of the acute lesions undergo rapid healing that it is obvious that gastroscopy is of greatest diagnostic value when done very soon, at most within two or three days after hemorrhage has occurred. We have done many of these early gastroscopies and have not seen any adverse effects, and we have often been able to demonstrate the source of bleeding in this way.

Gastric secretory studies may also add to the total diagnostic picture. The frequency of elevated acid levels in the fasting gastric contents varies a great deal but if the acid is high this does favor duodenal ulcer disease as the cause of hemorrhage. Generally, however, detailed gastric analyses are not carried out in patients who have bled recently, although it has been claimed that by combining this with x-ray and gastroscopy it is possible to establish the diagnosis of peptic ulcer disease, either acute or chronic, in as many as 80 per cent of patients in whom this has caused hemorrhage.[3]

Evaluating the Severity of Hemorrhage

The interplay of many factors complicates the problem of determining whether hemorrhage is to be classified as "massive" or "severe" or "moderate." There is no easy way to measure the amount of blood lost from the vascular tree and the clinical and physiological effects of a hemorrhage vary not only with the quantity of the bleeding but with the speed of bleeding, the age and cardiovascular status of the patient, and his hemoglobin level when the bleeding occurred. Thus, a relatively small secondary hemorrhage in a person who has barely re-stabilized after an earlier hemorrhage may have very dire consequences. Gauging the effect of a gastrointestinal hemorrhage is often a matter of astute clinical judgment rather than a simple laboratory formula.

Certainly the severity of a hemorrhage is not revealed by hemoglobin and hematocrit determinations immediately after the hemorrhage. Some time may elapse, up to several days in some patients, before fluid administration and re-distribution of tissue fluids restore blood volume and with this bring blood dilution that is reflected in a low hemoglobin reading. It is obvious, therefore, that the initial blood count is hardly an accurate measure of blood loss. A variety of methods to measure blood volume and red cell mass have been suggested for use in patients who have bled but none has gained universal application, although some of the radioisotope dilution technics are awaiting further clinical testing. Determinations of blood urea nitrogen may give some clue both to the site of bleeding and to its volume and the severity of its effect on the patient. Elevations of the urea nitrogen frequently occur following bleeding high in the gastrointestinal tract and very high readings may follow massive bleeding in elderly individuals with poor renal function. Marked elevation, to 80 or 100 or more, is seen occasionally and such high readings are generally associated with a poor prognosis both because they indicate the severity of the hemorrhage and also because they frequently reveal poor vascular and renal reserve. Ordinarily, however, the initial blood counts and urea nitrogen levels are of little immediate help in evaluating the status of the patient.

The time-honored clinical signs of pulse rate and blood pressure and general reaction and appearance of the patient are the features relied upon most frequently to gauge the effects of a hemorrhage. Crude as they are they offer the greatest assistance in evaluating the emergency, particularly since what we are assessing is not so much the volume of blood

loss but the ability of the patient to withstand the loss. Therefore, such clinical features as manifestations of restlessness and anxiety, sweating and pallor, speed and volume of pulse, ability to maintain a stable blood pressure, all enable the alert physician to judge the status of the patient. Continued rapid pulse, low systolic pressure, low pulse pressure, are all signs of continuing bleeding and if these recur after a period of apparent improvement we must assume that bleeding has started once more.

In some cases it is of assistance to carry out a "tilt test" as a means of recognizing shock.[6] It has been shown that in bleeding patients in whom adequate hemodynamic adjustments are not being achieved, tilting the body to +75 degrees for three minutes causes a drop in blood pressure and a rise in pulse rate of more than 30. This type of response to the tilting may be considered a good indication for transfusion and a continuing positive tilt test is often seen in patients who are continuing to bleed.

It is probable that greater experience with a wider use of central venous pressure readings will help to develop more accurate and better standardized measurements of shock and the need for blood replacement. In the absence of these readings, failure to stabilize arterial pressure and pulse rate after transfusions is the major sign that bleeding is continuing and that serious consideration need be given to surgical intervention.

Medical Treatment

Since nothing short of surgical handling of the bleeding lesion can assure hemostasis the medical therapy of upper gastrointestinal bleeding is really restricted to supportive measures. These include blood replacement as this is required to relieve shock and to restore blood volume, the maintenance of fluid and electrolyte balances, the rational use of mild sedation, and the assurance of reasonable nutritional support until a more normal diet can be resumed. In patients with cirrhosis the medical program must include, in addition to attempts at tamponade, to be discussed by Dr. Blakemore, measures to prevent hepatic coma. The role of the internist in the actual therapy of gastrointestinal bleeding is therefore one of tiding the patient over the emergency and judicious efforts to find the cause of the bleeding. It is also most important for the internist to maintain constant association with the surgeon to be certain that conservative non-surgical methods of treatment are not relied upon beyond a reasonable point so that if surgical intervention is necessary it can be utilized at a time when the patient is still in reasonably good general status.

Many of the fundamentals of medical management are obvious and need no comment. The patient should be hospitalized and at absolute bed rest with frequent observations of pulse rate, blood pressure, and general clinical status. Initial laboratory studies should include hemoglobin and hematocrit, typing and matching of blood for tranfusions, prothrombin determination and determinations of the urea nitrogen, serum bilirubin and the response to a bromsulphalein test. The hemoglobin and hematocrit should be repeated every six hours. Fluid intake and output records should be kept. In many cases it is helpful to pass a nasogastric tube to note the quantity and freshness of any blood in the stomach. When bleeding seems to originate in the stomach itself lavage with ice water may have some hemostatic effect. Gastric hypothermia has also been used with success for this purpose. Some sedation is usually needed and phenobarbital and Chlorpromazine are satisfactory for this. Morphine should be avoided.

If vomiting has occurred or the patient is nauseated oral feedings should be withheld and fluids given by vein. Otherwise, there is no contraindication to early feedings. I have usually relied upon hourly milk feedings rather than more elaborate and fuller diets which have been suggested in some centers. I see little need for antacids in the immediate post-hemorrhage period.

Patients who show any of the signs of cirrhosis should be treated in a way to forestall coma

and should be given large doses of milk of magnesia and saline enemas to get rid of accumulated blood in the bowel and should also be given a poorly absorbed antibiotic such as Neomycin in a dose of 4 to 6 gm. daily. In these patients, also, it is best to eliminate oral protein intake until the patient's general status can be observed over a period of time. Oral feeding, if any, should be restricted to carbohydrate liquids. Also, in these patients, if varices seem to be the source of bleeding an attempt to control this may be made with one of the balloon tubes that are available or hypothermia may be used in an attempt to check the bleeding.

Transfusions are indicated, of course, if there is any evidence of shock. If blood is not immediately available glucose and saline or dextran can be given as temporary measures. The quantity of blood to be given must be determined by the patient's general status. It is important to give enough to correct shock, with careful consideration of the patient's age and cardiovascular status. 1500 to 2000 c.c. may be needed in the first 24 hours and, since the amount that will be required is unpredictable, provisions for multiple transfusions are necessary. Failure of rapid transfusion of blood, in increments of 500 c.c. to a total of 3000 c.c., to achieve and maintain circulatory stability is the most reliable indication that bleeding has continued or recurred and that prompt surgery is needed.

One can state the indications for surgical intervention in terms that few would criticize. These include continued or recurrent bleeding, severe bleeding that is difficult to control in an elderly patient, bleeding from a known chronic gastric ulcer or a gastric neoplasm, and the presence of associated disease such as cardiovascular or pulmonary disease that increases the risk of hemorrhage. No situation in medical practice, however, calls for more skillful judgments or imposes greater need for prompt decisions. The indications are simple to state but so difficult to apply to individual patients. The internist must recognize those situations in which bleeding will not stop and in which prolonged efforts to avoid surgery can result only in greater and greater depletion of the patient, thus adding immeasurably to the risk of operation when this is finally done. The surgeon must recognize those situations in which a little time may permit bleeding to stop or a period of study may determine the site and cause of bleeding so that if operation is necessary it is assured a greater chance of success, with reduction of some of the post-operative difficulties. Here, as much as any place in medical practice, the skills and knowledge of both surgeon and internist should be combined to reach decisions that are of greatest advantage to the patient. Only by these combined efforts can the mortality of hemorrhage be reduced to the minimum.

Finally, the responsibility of the physician does not cease when the patient's bleeding has stopped either spontaneously or after an operation. Every effort must be made to determine the cause of the hemorrhage, to be certain that the underlying disease is treated and future recurrences prevented, and, in those patients for whom major gastric surgery has been necessary, that the effects of gastrectomy are minimized.

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1830 Rittenhouse Square

DINNER DANCE

Tuesday Evening, May 17, 1966

The speakers' section of the program was convened at 8:30 p.m. Mr. Richard I. Nevin was Toastmaster. Mason W. Gross, Ph.D. was guest speaker. The title of his presentation was *One To Grow On.*

The Toastmaster: It is my pleasure to introduce Dr. Nicholas A. Bertha, chairman of the Board of Trustees.

Dr. Nicholas A. Bertha: Ladies and gentlemen: The Medical Society of New Jersey has waited two hundred years to enjoy this shining hour. I count myself deeply honored to have the privilege, as chairman of the Board of Trustees, in the name of The Medical Society of New Jersey officially to welcome you to this gala bicentennial dinner. May all the highest hopes of those who planned this evening be richly realized. May each of you have such a joyous and heartwarming experience here as you will always delight to remember. You are most welcome, all.

(Applause)

The Toastmaster: And now, ladies and gentlemen, Mrs. Lewis C. Fritts, president of the Woman's Auxiliary, will bring you greetings.

Mrs. Lewis C. Fritts: It is an honor for me, as president of the Woman's Auxiliary, to bring greetings to The Medical Society of New Jersey on this, their bicentennial year. We bring our most sincere congratulations and good wishes, and hope for them many happy returns of this evening. Thank you. (Applause)

(Introductions: officers and official guests)

The Toastmaster: Ladies and gentlemen: The moment is here when we make some references to the guest of honor. One of the unplanned honors enjoyed by our guest of honor is the circumstance that he is the president of The Medical Society of New Jersey in its bicentennial year.

In the course of this enchanted evening I have had an eerie feeling that we are not alone. I sense the unseen presence of others who, beyond the pale of time, somehow are with us here tonight — John's mother and father, and the officers and members of The Medical Society of New Jersey, who are leaning over the ramparts of Heaven to share with us the pleasures of our celebration. In the words of Jeffrey O'Hara, "I tell you they have not died; they live and breathe with you."

To you and to them, I present the President of two centuries of waiting — a thoughtful, courageous, honest, amiable, good man, good friend, and good doctor — John J. Bedrick, who will now be inducted by Dr. Calvin into the fellowship of the former presidents of The Medical Society of New Jersey.

(Standing ovation)

Dr. Charles H. Calvin: John, your term as president is about over. You've just about completed your tour of duty, and you have done well. You have served us well, with honor and distinction. Now you are going to come in with us old Fellows, the past-presidents. There's going to be a sudden change. There will be fewer phone calls, less mail, and fewer committees to meet with. Somehow you're going to go back to your old routine in the office. Boy, it's going to be enjoyable.

(Laughter)

But somewhere in here, it's not the women in your life but the life in your women that kept you so young. (Laughter)

And that old adage of age before beauty — he never believed in that one. Did you ever see John go in front of one of these young, blonde, curvaceous individuals; go ahead of her in a revolving door? No, sir.

Anyway, John, you don't have to go to the Chase Manhattan Bank for your friends; they are all here tonight, and on their behalf let me give you this token of their esteem of you.

(Applause)

Dr. Bedrick: Thank you very much.
Somehow or other, when you have something like this bestowed upon you, it leaves you wanting for words, and that's usually not one of my faults.

This is a deep moment for me. I am appreciative of the honor, and I'm grateful to the Society for having elected me. I'm proud of your judgment of my services to you. I'm grateful to the people from Hudson County who supported me here — Joe Donnelly for having nominated me. I must acknowledge thanks to Dick Nevin for having guided me through many of the deeper and more troubled moments of this year.

I must also publicly thank Dr. Nat Plavin who engineered two of the best parties I have ever been to. Being an old Army man and retired now, too, I got a party for that; but believe me, it wasn't half as nice as this.

I want to tell you that you rise from the troops, you have to take care of the troops, and to the troops you must return. With this I say my swan song, and I bestow the halo of office and the gavel of dignity on that Turbulent Turk, Colonel Joe Jehl, who, I'm sure, will do at least as good if not a better job than I did. Thank you very much. (Applause)

The Toastmaster: And now, since it is more blessed to give than to receive — to make John the happiest person possible, he has the happy task and privilege of presenting to Mrs. Fritts her Fellowette's Pin as she joins the Fellowettes of the Woman's Auxiliary.

Dr. Bedrick: It's, indeed, a pleasure to put my arm around this gracious lady. Besides the recognition of her own achievements in the Society — of the grateful thanks which I have to give her for the help and assistance of her Woman's Auxiliary — I must call attention to the fact that her husband was also a Fellow of The Medical Society of New Jersey. Her daughter is married to a physician; and maybe when he comes back, he will follow in the footsteps of his late, and much-missed father-in-law.

Mrs. Fritts, it is with deep gratitude for your help, for your service, and for your encouragement; and many tributes to your graciousness, that we bestow this pin upon you. Thank you! (Applause)

Mrs. Fritts: Thank you.

Dr. Bedrick, it's a great pleasure to receive this. I received this other pin from the Auxiliary. And I am one of those persons who does not think that a past-president is a has-been.

Dr. Bedrick met me in the elevator the other day and he said, "Well, we're almost a couple of has-beens." And I don't agree with him. I think past-president is the best job to have. Thank you very much. (Applause)

The Toastmaster: Ladies and gentlemen: With your indulgence we will make a slight change in the order of the program. Miss Albanese wishes to return to New York tonight, so at this time I present Miss Licia Albanese of the Metropolitan Opera, who will sing to you. (Musical Entertainment)

The Toastmaster: Ladies and gentlemen: When a hundred years ago this Society was celebrating its centennial, the faculty at Rutgers participated in the celebration. This, of course, was very proper because Rutgers University was also chartered in 1766. It's not quite as old as The Medical Society of New Jersey, because Rutgers was chartered in November, 1766, while we were established on July 23 — in Duff's Tavern in New Brunswick. Rutgers is thus a somewhat younger institution and we are delighted to associate with it.

When thinking of this occasion, it is therefore only fitting that again we turn to Rutgers. We are delighted that the president of Rutgers consented to come and join us and to speak to you.

I don't think he needs an introduction. You know him, I'm sure, as a philosopher, teacher, lecturer, speaker, TV personality, and outstanding college president — Dr. Mason W. Gross. (Standing ovation)

Dr. Mason W. Gross: Thank you, Mr. Nevin, and ladies and gentlemen for this warm reception, indeed.

I have for years had a colleague now retired, whom I think many of you have often met — Dr. Houston Peterson. Dr. Peterson has lectured all over the United States with a great deal of success. But he always said the thing that fills him with holy terror is to have to get up and speak just after a beautiful soprano has just sung.

He told a story about a time when he was down at the Rice Hotel in Houston, Texas. Just before he was to get up to speak, all of a sudden they introduced a soprano with the rather interesting name of Mrs. Daniel Boone. And he said when he got up to speak, just about to start, all of a sudden at the table down in front of him he saw Mrs. Daniel Boone. She had left the stage and had gone down to sit with her friends. And he said in a wild, mad moment — he was going to lecture on American History — and in a wild moment he said, "Madam, where is the great pioneer? Where is the great frontier-breaker? Where is the terror of the forest? Where tonight is Mr. Daniel Boone?" He thought, my God, what have I said? Where is he? And she rose up very sweetly and said, "He's home baby-sitting." (Laughter)

I think tonight is an occasion for a party, and I'm certainly not going to harangue you for a great length of time. I bring you the greetings of a junior member of the two hundred anniversary variety and wish our senior members here all success.

The Bergen Festival Orchestra from Norway played in our concert series this year and presented us with a scroll. The man who gave the scroll revealed that they were 201 years old. This is rather an accomplishment for an orchestra. I think it's the oldest continuing orchestra in the entire world. But I thanked him very much. I congratulated him on his 201 years and said that frankly, as I say to you tonight, I like to associate with older people. (Laughter)

I will tell you on the score of brevity an explanation of how a speaker can be brief. Every year we have a luncheon meeting of the Annual Business Conference at the University. The speaker last year was the President of the Metropolitan Life Insurance Company in New York. He said: "I'm supposed to be through at 2:45, and I can guarantee that my speech has been timed and I'll be out of here by 2:45 and so will you." He said, "As a further assurance, at 2:45 I have an appointment with my psychiatrist. If I'm not there on time, he goes ahead by himself." (Laughter)

As for this Duff's Tavern — you are not the only people who can claim to have been born in a tavern. I agree you are older and all that. That tavern in New Brunswick was undoubtedly a distinguished hangout. Rutgers started under the sign of the Red Lion, also in New Brunswick, probably a tavern just a couple of doors down the street. I think they probably had a tavern for every other house in New Brunswick, then, as now. (Laughter)

As a couple of tavern-born kids, I think we pretty well survived our two hundred years.

I'm pleased — I had not known that we were here at the one hundredth anniversary of this Society. Those first hundred years must have been difficult ones for both the Society and for the College. As I look back at the studies of the curriculum which were taught at Rutgers in those days, it must have been pretty grim. And there's been a book published by a man named Rudolfs at Williams College, which presents an interesting thesis. It is that probably in all the entire history of American colleges and universities — but certainly during the first one hundred years of our existence — probably every single innovation in a curriculum, every single advancement in the intellectual life of the students was brought about by the students in spite of the faculty and over the dead bodies of the trustees. (Laughter)

And I suspect it may be in those same first hundred years of our growth, not of course today, that probably most of the advances in medicine may have come in over the dead bodies of The Medical Society of New Jersey. I'm not sure.

But those were not innovative days; those were days when you more or less fixed your eyes on what was going on in Germany or what was going on in Edinburgh or something like that, and what went on in this country was a pale reflection of that.

It's different today, and one of the differences has been the development of land grant colleges. The important thing about the land grant movement was that for the first time in any country in the world, I think, it really tied in the notion of education and research to the whole economy of the nation. In other words, you didn't just simply go ahead and put the case through with Latin grammars and so on whether the people needed it or not. You realized that education and educated people were essential to the health and welfare of our entire country. We have not since that time — at least in the land grant colleges, of which Rutgers is one — lost that sense of dedication.

It has taken us two hundred years essentially for what is now the State University of New Jersey to get around to medical education. There was an abortive attempt back in the early part of the nineteenth century when Rutgers opened a medical school in New York City. I don't know whether this was a successful school or not, but it was successful enough for the other medical schools in the city to decide this had to be stopped. So they managed to get a rule put through that a college in one state could not grant degrees in another state. That quickly closed the Rutgers Medical School, which then moved up to Syracuse and became the origin, I believe, of what is now the Upstate Medical College of the State University of New York. That was our one brief venture in the nineteenth century into the field of medical education.

In the time between then and now — because in September we as a State University will receive our first medical students — in the time between then and now, a great deal has been done in the sciences and the other professional groups which have relations to the medical school but are not of medical school quality. Our scientific departments have done a tremendous amount of work, and I think the testimony by the presence of Dr. Waksman here tonight shows what Rutgers has been able to contribute to medical science over those years.

We also developed a College of Pharmacy. In fact we took it over, really. It was founded in 1892, and became part of the University in 1927. We now have a College of Nursing in Newark. With all these, plus the Institute of Microbiology and the Biologic Science Department and the Bureau of Biologic Research, a great deal has been going on in the University which relates to medicine; but it has lacked the focus which would be brought about by the establishment of a medical school.

You will recall the bond issue some years back which tried to persuade the voters of New Jersey to establish a State Medical School. It was defeated. After that, Seton Hall University started in the hope of being able to swing a medical school by itself on a private basis. Here they ran into tremendous difficulties, most of them financial; and, as you know now, that has been taken over by the State of New Jersey as the New Jersey College of Medicine. We are grateful to Seton Hall for having established the first medical school in the State and getting us underway.

After the defeat of the bond issue, we were rocked back on our heels for a while. Finally it was decided to see if we couldn't do something at least by way of a two-year medical school. We had the example of the Dartmouth School. We knew that other schools of this sort were being founded across the country. We thought we could start with a good two-year school and develop a really good program in basic medical sciences. And that is as far as we are now. We were able to raise nearly six million dollars from foundations and corporations, mostly here in the State, and from individuals, considerable money coming in from members of the medical profession and from county medical societies. We did get our six million dollars, of which a good part could be used for construction purposes.

We then went to the State. The State agreed to match that with a six million dollar grant. With that money we went to the federal government and got $8,200,000. So this summer we will start to erect an $18,000,000 building on the University Heights Campus in Piscataway Township. This will be devoted to the education of medical students for their first two years. We have assurances from many medical schools that they will take any students that we recommend to them as being fully qualified at the end of those two years, so they can complete their studies there.

The more we have been planning and trying to organize a two-year school, the more we have realized that New Jersey deserves more than this. The New Jersey College of Medicine can turn out 80 to 100 students, perhaps, every year. This is not enough. We ought to be able to double that number in New Jersey and the State ought to make a contribution to it.

So we are now planning to go ahead. We discovered, for example, that it is hard to secure a faculty who are going to be content with a two-year school. If it were only the basic sciences perhaps we could swing it. But as you know, the medical school now must teach both medicine and psychiatry for all four years of its program; and to get good people in the field of medicine or in the field of psychiatry is difficult unless they are going to have students during the third and fourth year. Furthermore, the best students, if they can be admitted to a four-year medical school or to a two-year medical school, don't see why they should pick the latter and then have to switch in the third year. So to be on a competitive basis from New Jersey's point of view, we are now planning to go right ahead with our four-year school.

We don't know yet what the cost will be. There are many factors — such as the size of the hospital that ought to be built as part of the teaching program of the school. We don't know exactly what's going to happen to other clinics which may want to associate themselves with the medical school. We do have, fortunately, quite a good deal of land, but we don't know what all the plans will be.

This thing will probably cost (over and above the two years we have money for now) somewhere in the neighborhood of $75 million. Thus, the problem of getting this underway is going to be a serious one. Thank heaven the State of New Jersey has recognized the fact that education and medical care cost money and have taken the initial step by providing additional revenue. Perhaps now we are a bit nearer thinking about this thing in realistic terms than before.

If we could count on great help from the federal government and on all the legislation passed which will give us that help, we could probably reduce the $75 million total cost to something between $30 and $35 million so far as the State is concerned. But now of course we are worried about inflation and the kind of brake that's been put on in Washington on new construction projects for fear they will contribute to inflation. So I am not quite sure what our timetable will be so far as securing this federal money is concerned. However, it is our intention to proceed with a full four-year school, with the hospital and clinical facilities necessary to the education of the students in that school. This will not be another community general hospital or anything like that. It will be a hospital closely tied to the purposes of the medical school itself.

And I repeat what is not often clearly understood: the purpose of this medical school is to graduate M.D.'s to start practicing, hopefully, here in New Jersey and adding to the supply of doctors which New Jersey so badly needs.

Of course, with that whole program of education and its primary purpose, there must be a program in research. No medical school today can survive, or retain or attract an able faculty, unless there are research possibilities available to them. We all know how rapidly medicine is changing and we know that no professors of the medical sciences or clinical sciences will be content to go to a school

which does not have an active research program. But that is, as I say, all part of the total project. Our primary purpose is to turn out medical students, and this I think we are going to be able to do.

To this date we have attracted an extremely able faculty. There is a great deal of willingness on the part of the various government agencies to give them the support they need.

In New Brunswick we have an ideal location. I have often talked about the fact that so many highways lead to New Brunswick. All of a sudden, they started leading themselves right across our campus in kind of a crisscross of concrete, which is a little closer than I had hoped for. But, at least, it does underscore the fact that New Brunswick and Piscataway Township are in the so-called waist of New Jersey — w-a-i-s-t — and all the highways seem to converge there and branch out coming from all parts of the State. So we will be able to serve the needs of the State in that way.

Now I go back to the fact that we are a land grant college. The instructional program which we will carry out there is, as it was in the early nineteenth century, the heart of the University. Any university exists from the point of view of bringing out students, educating students, graduating people with the appropriate degree. That's their primary purpose. Research is a secondary part of that enterprise; but a secondary part in terms of its intellectual force which is of tremendous and vital importance to the advancement of science in this country. But more than that is the third concept, which is service to the community. This is what the land grant philosophy essentially was designed to bring about. And I assure you that this will be one of the primary purposes of the whole medical school as it is of the entire University.

We know that we are the State University of New Jersey; we know we are a land grant college of New Jersey designed to try to help New Jersey solve its problems. Whatever this medical school can do with the State Medical Society, the county societies, with the hospitals, with the medical profession in the various cities and towns of the State, this is what we are going to do to the best of our ability. We are always going to have a staff with a finite size. There will be just so many jobs they can take on, so many things that we can do without diverting ourselves from our basic purpose of educating students. But to the extent to which we can cooperate with this Society and the county societies which come under it and the hospitals, and the other medical institutions in the State, this is something that we are dedicated to doing.

We have often talked about the State's University as the keystone of the whole educational system of New Jersey. I hope our medical school can serve the same kind of function to all the programs of medical education going on through your societies and in your hospitals all over the State. I hope we can establish close connections with you, both from the point of view of your intern and residency programs and in research problems which may turn up in your activities with which you'd like to have us follow through.

I gave my title. I'm always asked for a title at least six months before I have the slightest idea whom I'm going to talk to, what I'm going to talk about. It seems I had a fairly safe title tonight. We are both celebrating birthdays, and therefore my title is "One To Grow On." What I'm saying is that as we celebrate our two hundred years of history, as we are proud of what has been accomplished, what our forbears have done for us, we are still looking forward into the future.

The statement a while back that some of our ancestors were peering over the rim of Heaven and having a look at us here tonight does not altogether please me. Almost all my ancestors in the presidency of Rutgers were a bunch of rigid teetotalers who would have frowned desperately at the idea of my sitting up here, having a drink. I think we have progressed since those days, and I am happy that two hundred years have got us somewhere.

But I'm more concerned now about what is

going to happen during the next two hundred years than I am over what has gone in the past. One thing we know is that the rate of change, the rate of development, the rate of growth has tremendously accelerated. During the first hundred years of our existence the rate of change was almost that of a snail. It has been gradually increasing since then with a tremendous surge in science of all kinds since the second World War. And what all these new scientific developments mean to medicine, science, and medical technology, and what is forecast it's going to mean for the next ten years, to say nothing of the next two hundred, is something that simply takes your breath away. We've got to be ready, we in the profession, we in the colleges and universities, for a tremendous amount of change. We must keep ourselves up to date. Otherwise we will simply be bypassed by the young fellows coming along. There are going to be so many new ideas, so many radically new concepts as this science moves into the immediate future, to say nothing of the long-range future, that we've got to be ready and got to be alert. The key to the whole program is going to be education and along with education the essential research that must go with it.

As we move into the second two hundred years of our existence, may I simply say to you that I do hope the University and The Medical Society of New Jersey can grow closer together. Our interests have finally met and coincided after all these years. Working together, there is a great deal that can be accomplished.

In many states, friction has developed between the medical school and the medical societies, sometimes local, sometimes statewide. I promise you that any friction of that sort that I can help avoid, I will. I don't expect it here at all; I don't find it in the atmosphere; but elsewhere it *has* happened. We've got to be prepared, because it's working together that is going to be the key to our success in the future. Cooperation between the University, its Medical School, and the State Medical Society can bring New Jersey to a level of patient care which was never known before. I think we have fantastic things in this year to go on and in the next several years to come. I sincerely hope we keep in close touch with each other in full cooperation because there is much that we can accomplish in that way. Thank you very much.

(Applause)

The Toastmaster: Ladies and gentlemen: As I extend to Dr. Gross our appreciation for his fine presentation and his presence here this evening, in my own person I should like to offer the solacing thought that perhaps those predecessor presidents, now that they are in Heaven, teetotalers though they were on earth, have now a better sense of value.

(Laughter)

This is an evening of tribute to The Medical Society of New Jersey, and I hope that I may indulge myself in the privilege of paying one on my own behalf in the form of some lines that I wrote. I think every celebration should have a little bit of versification in it. And John Bedrick wouldn't do any writing for me, so I offer this to this Society:

Of stuff more sturdy than enduring bronze,
On footings strong and deep as is the sea,
This edifice is built, and in it lies
Rich records, wrought of love and constancy.

Its story is a chronicle of love —
Such love as flowers not from passion's sod,
But love that binds men strongly, heart to heart,
As children of their common Father, God.

Thus far, two hundred golden years have passed
Since builders first began to ply their art.
Each offspring generation has in turn
Supplied successors trained to play their part.

Our task today, as theirs who went before,
Is by our life and work to higher raise
The level of the structure they began,
Whose deeds impartial history notes with praise.

Their dreams be ours, their characters, their wills
That we, as they, may help our fellowmen
To slip the anguished bonds of pain and grief
And walk the world in health and joy again.

(Applause)

Now, ladies and gentlemen, if you will all rise, Mr. King has agreed that we will sing together "Auld Lang Syne."

Ladies and gentlemen, this ends the formalities of the evening. The Two Hundred Club will continue, with dancing for all who so desire.

(The formalities were concluded at 9:35 p.m.)

STATE ACTIVITIES

Address of Retiring President*

John J. Bedrick, M.D.

I recall that on the eve of his retirement, General Summerall was asked what he planned to do when he returned to civilian life. He replied, "Well, for the first two weeks I am going to sit quietly in my favorite rocker on my front porch . . . and then — I am going to begin to rock gently."

Perhaps I shall not be quite so relaxedly inactive, but I am looking forward to the enjoyment of unaccustomed freedom from demanding concerns, and to the pleasure of recalling all the many and varied experiences that will always be a delight to remember.

I shall remember the extensive travelling that I have done as your president, the interesting places that I have visited, the genial and gracious people whom everywhere I have met, the myriad matters of Society business with which we concern ourselves, the spirit of dedication of all my co-workers, and the deep satisfactions that I have enjoyed.

It was a great, active, interesting, instructive, and gratifying year. I enjoyed every minute of it. I would not have missed it for a million dollars, and I wouldn't do it again for five!

That realization makes me conscious of how much we all owe to those of our officers, councils, committees, and staff who successively, year after year, with never a diminution of dedication, devotion, or industry, give themselves to the service of our great Society. From all of them I have learned that for those who through self-sacrifice would come to know the fullness of accomplishment, the true slogan is not "Give until it hurts" but rather, "Give until it feels good." Under the inspiration of my co-workers, I have so given, and, believe me, I feel fine!

Presidents may come and go but the Society — which has already endured for two full centuries — continues on its vital way. What each of you must realize is that the Society as such is an abstraction that draws all its strength, all its drive, all its progress and character and power from the men and women who constitute its membership.

In proportion as each member gives of himself to the ideals, principles, and programs that identify the Society, to that extent is the Society enriched. And in proportion to its enrichment, the Society becomes increasingly potent as an instrument to maintain and advance the quality and standards of medical care and service, to further social and civic progress, to preserve essential freedoms, and better to serve mankind.

Each of us must realize that he has a duty as a member of the dedicated profession of medicine, to involve himself in all its contemporary concerns and activities. Never have times been more challenging; never have the opportunities for valuable service been as great. Each one of us is duty-bound to play an active part. No one can refuse to do so without branding himself as a sluggish evader of responsibilities that are his individually to bear.

The Medical Society of New Jersey has always been singularly fortunate in the number of good and able men and women willing to devote their best efforts and energies to the advancement of its professional goals and to the service of the general good. Let it be our prayer, in this the Bicentennial year, that now and in the years to come the Society will continue to grow in worth and worthiness because of the swelling ranks of those who see their duty and who do it.

* Remarks before House of Delegates, third session, May 18, 1966.

I am grateful to have had the honor of serving as your president. I pledge you my devotion and total application in any role that you may yet call upon me to play. I know of no worthier work than that which life calls upon us to do. I pray God that we may unitedly address ourselves to the doing thereof, and that we may continue to compile a valorous record of honorable and valuable achievement.

Thus, I take my leave of the presidency, but all of you I shall keep forever in my heart.

1966 Golden Merit Award

Following are the remarks of retiring President John J. Bedrick on the occasion of the Tenth Annual Bestowal of the Golden Merit Award at the 200th Annual Meeting of The Medical Society of New Jersey on May 14.

This Bicentennial Meeting is a period of wholehearted celebration, during which, in acclaiming the present worth and stature of our Society and of the profession of Medicine in America, we keep a tryst with Truth, and acknowledge, with respect and love, our indebtedness to the long line of our professional predecessors who have been the builders of the name and fame which we presently enjoy.

Of all the gatherings of this unique convention, this convocation this afternoon is the most important and significant. We are assembled in this pleasant place to present to a group of our colleagues, who wear as a garland the splendor of their lives, our tribute of gratefulness, to them and to all whom they represent, for the gifts of their giving to Medicine and Mankind.

The labors of Hercules are legendary, but they pale into inconsequence when compared to the labors and triumphs of the physician, through centuries without number. That the thralldom of disease and of death has been in great part lifted from oppressed mankind — that the thorny crown of suffering presses less heavily on its brow — is the result of the dedicated and enlightened efforts of medical scientists and practitioners, everywhere throughout the world.

These men and women who today are to receive the Golden Merit Award of The Medical Society of New Jersey are the latest in a long line of benefactors of mankind. Theirs was the youthful idealism that led them to consecrate their lives to the health and well-being of their fellowmen. Theirs were the ardor and the perseverance to work on, against harsh odds and bitter difficulties. Theirs have been the intellects eager for saving truth, the energies for great and long-sustained hard work, the hearts of true compassion, the hands of tender healing.

It is for all these reasons that we hail them today, for all these reasons that we honor them. As they have benefited our bodies, they have enriched our souls. In consequence, we are their debtors for riches that we have not earned but that they have freely and generously bestowed, for help delivered above and beyond the capacities or inclinations of lesser human beings.

My colleagues of the golden years, you are the adornment and capstone of our celebration. We thank God that you are here to lend distinction to our jubilee. We pray God that you may long be spared to add continued luster and warmth and inspiration to our lives!

RECIPIENTS OF THE GOLDEN MERIT AWARD

BERGEN COUNTY

Raphael Gilady, M.D., 205 Union Street, Hackensack

Lloyd Baldwin Whitman, M.D., 630 S.E. Fourth Avenue, Pompano Beach, Florida

CAMDEN COUNTY

Samuel Sumter Butler, M.D., 407—50th Street, Ocean City

CAPE MAY COUNTY

James Norman Coombs, M.D., 230 Ocean Road, Ocean City

CUMBERLAND COUNTY

Mary Bacon, M.D., 278 East Commerce Street, Bridgeton

ESSEX COUNTY

Abram Bernard Abrams, M.D., 2130 Millburn Avenue, Maplewood

Leon Jermain Camche, M.D., 250 Renner Avenue, Newark

Maurice Cohen, M.D., 106 Valley Road, Montclair

Joseph William Gardam, M.D., 16 Longfellow Avenue, Newark

Nathan Bernard Heller, M.D., 3200 Harrison Street, East Orange

William Frank Krone, M.D., 31 Lincoln Park, Newark

Francis Joseph McCauley, M.D., 140 Roseville Avenue, Newark

William Anthony Nyiri, M.D., 869 Cieneguitas Road, Santa Barbara, California

Arthur Gilson Pilch, M.D., Box 34, West Boothbay Harbor, Maine

Abraham George Reinfeld, M.D., 354 Clinton Avenue, Newark

Herbert Steiner, M.D., 650 Stuyvesant Avenue, Irvington

Edward Hallick Willan, M.D., 110 Ocean Grove Drive, Ormond Beach, Florida

HUDSON COUNTY

John Anthony Botti, M.D., 157 Wegman Parkway, Jersey City

Sophia Levinson Halpern, M.D., 1311 Palisade Avenue, Union City

John Vincent Kearney, M.D., 335 — 78th Street, North Bergen

Miles Thompson Long, M.D., 2150 Kennedy Boulevard, Jersey City

Frank Peter Nicholson, M.D., 301 Boston Boulevard, Sea Girt

MERCER COUNTY

Allen Ross Pittman, M.D., 165 Fenwood Avenue, Trenton

PASSAIC COUNTY

Sidney Charles Levine, M.D., 39 East 39th Street, Apt. 3-I, Paterson

Louis Lipton, M.D., 67 Passaic Avenue, Passaic

Harold Milton Stein, M.D., 227 West Broadway, Paterson

UNION COUNTY

Julius Gerendasy, M.D., 380 Irvington Avenue, Elizabeth

Thomas Maurey Morris, M.D., 953 Prospect Avenue, Plainfield

Rocco Marion Nittoli, M.D., 220 West Jersey Street, Elizabeth

The Healing Art

A comprehensive one-volume history of the nation's oldest state medical society, *The Healing Art: The Medical Society of New Jersey Through Two Centuries, 1766-1966*, is one of the highlights of the Society's Bicentennial year. Carefully compiled by the Society's archivist-historian, Fred B. Rogers, M.D., with the collaboration of A. Reasoner Sayre, this chronicle provides a readable and factual record of the medical and scientific heritage of the Garden State.

The Healing Art will depict medical advances from the herbs, "simples," and incantations of the 1600's to the public health measures and the antibiotic "wonder" drugs of the 20th century. Hundreds of New Jersey communities and familiar family names dot the pages of *The Healing Art* as it marks the development of MSNJ in New Jersey. Anecdotes ranging from a pre-Revolutionary grave snatching for medical instruction to a doctor's bequest of ice cream cones for school children portray the unceasing efforts of the profession to make life longer and happier for each succeeding generation.

A 350-page book with 75 illustrations, its cover design and page layout were done by Homer Hill, eminent New Jersey artist. The book is being produced by the Printing Corporation of America, which has published among other outstanding volumes the *Time-Life* series on geography, history, and the arts.

A copy of *The Healing Art* will be mailed to each member of The Medical Society of New Jersey during the summer. Additional copies will be available for purchase at $10.00 per copy to other professional groups, interested persons, and the general public, as part of the Bicentennial observance.

Documenting two centuries of distinguished professional achievement, the book is the product of several years of meticulous research and writing, and should be useful as a source of authoritative reference for years to come.

BICENTENNALIA

William Carlos Williams: Medical Man of Letters

The death of Dr. William Carlos Williams on March 4, 1963, at the age of 79, closed an unusual career — a practicing physician who was one of the leading poets of the twentieth century. Though acclaimed as an author during his life, the full impact of his individualistic, highly American style of writing has yet to be felt. In a *William Carlos Williams Reader* (1965), for example, the editor, M. L. Rosenthal, professor of English at New York University, said of Dr. Williams: "No writer has ever discovered himself more sensitively in his work than this toughminded, affectionate, sensuously alert yet self-disciplined and perfectly honest poet, who was never fully enough honored by his country in his lifetime."

William Carlos Williams was born at Rutherford, New Jersey, on September 17, 1883. He had a cosmopolitan background: his father was an Englishman and his mother a Puerto Rican. The son traced his ancestry to English, Spanish, French, Dutch, Danish, and Jewish roots — and this mixture of strains may have contributed to his own diverse talents. After attending schools in Switzerland, France, and New York, he entered the University of Pennsylvania School of Medicine in 1902 and received his M.D. degree four years later. While a medical student he took part in the activities of the Mask and Wig Club and befriended Ezra Pound and Hilda Doolittle, who figured in the *avante-garde* group of American poets — the Imagists — in the 1920's.

Dr. Williams interned at the French Hospital in New York City during 1906-07 and then worked at the Nursery and Child's Hospital. Next came a postgraduate period at Leipzig, Germany. A first book, *Poems,* was privately published in 1909. His first "commercially published" book of verse, *The Tempers,* appeared in London, England, four years later.

Williams became an early contributor to *Poetry* magazine, which was founded in 1912. His wife, née Florence Herman, reassured him when his own first selection of verses sent to the magazine were rejected. She herself thereupon chose a batch of his poems — these were all accepted and published in 1913. After his death, his widow gave a collection of his first editions to the Van Pelt Library of the University of Pennsylvania.

Dr. Williams began medical practice a half-mile from his birthplace, at Rutherford, in 1910. He served the Rutherford, Lyndhurst, and Paterson area for forty years; delivered over 2000 babies; and was president of the medical staff of the Passaic General Hospital. Retiring from practice in 1951, shortly after completing his *Autobiography,* he was succeeded in pediatric practice at Rutherford by his son, Dr. William Eric Williams.

William Carlos Williams' literary output included thirty-eight books of poetry and prose, including *Paterson,* a five-volume mixture of both. Much of the pablum for his writing came from the people of Italian and Polish background whom he attended as a physician. Searching for "the American grain," the Doctor wrote while caring for his patients. One of his best short stories is "Old Doc Rivers," a character study of a brilliant but eccentric surgeon who practiced in Rutherford when Williams was a young man. Gusto and realism pervade his novels, plays, and essays, too. In a posthumous tribute, TIME magazine (March 15, 1963) noted: "He was both poet and physician, each as a profession in itself, and each thanks to the other. He had mastered the knack of treating poems as patients and patients as poems, and both were the better for it."

Writing poems between patients, Dr. Williams stated: "To treat a man as material for a work of art makes him somehow come alive to me. . . . I'm a pediatrician. I take care of babies and try to make them grow. I enjoy it." In free verse, the patients moved among the sharp images of industrial New Jersey and the real life exhibited there. His poems were like snapshots — direct, abrupt glimpses:

> gotta hold your nose
> with the appropriate gesture
> smiling
>
> back of
> the garbage truck
> as the complex
>
> city passes
> to the confession
> or psychiatric couch or both.

In native cadence, lines like —

> You can do lots
> if you know
> what's around you
> No bull

— while meaningful in New Jersey, were often baffling in Europe, even in the best translations.

In the medical field, *Complaint* is an example of his unique style:

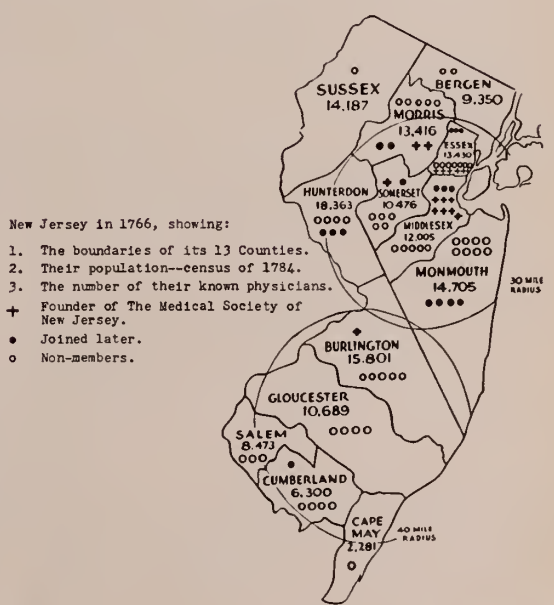
> They call me and I go.
> It is a frozen road
> past midnight, a dust
> of snow caught
> in the rigid wheeltracks.
> The door opens.
> I smile, enter and
> shake off the cold.
> Here is a great woman
> on her side in the bed.
> She is sick,
> perhaps vomiting,
> perhaps laboring
> to give birth to
> a tenth child. Joy! Joy!
> Night is a room
> darkened for lovers,
> through the jalousies the sun
> has sent one gold needle!
> I pick the hair from her eyes
> And watch her misery
> with compassion.

A volume of reminiscences about his works, *I Wanted to Write a Poem,* probably the best introduction to them, appeared in 1958. Numerous honors came to this creative writer: he won the Dial Award for services to American Literature (1962), the National Book Award for Poetry (1949), and the Award of the Academy of American Poets (1957). In May, 1963, he received posthumously both the Pulitzer Prize and the Gold Medal of the National Institute of Arts and Letters.

Speaking at a Bergen County Medical Society meeting shortly after his election to the prestigious American Academy of Arts and Letters (1958), Dr. Williams told his colleagues: "You are my pals and I am proud to have been a physician. This is my home, and whatever distinction I have achieved stems from the conviction that in the United States we speak our own language, not just English. This is my inspiration. The American idiom is my forte, and I am proud to be known as a poet and proud to have been a doctor."

Fred B. Rogers, M.D.

New Jersey in 1766



State of New Jersey

THE SENATE
STATE HOUSE, TRENTON, N. J.

SENATE CONCURRENT RESOLUTION
By Senator RIDOLFI
Adopted June 15, 1966

A CONCURRENT RESOLUTION of congratulations and best wishes to The Medical Society of New Jersey upon the occasion of its Two hundredth Anniversary.

WHEREAS, The Medical Society of New Jersey, the oldest medical society of the United States, having been founded 10 years before the independence of our country, is celebrating, in annual convention at Atlantic City, May 14 to 18, the Two hundredth Anniversary of its organization; and

WHEREAS, The Medical Society of New Jersey and its members have rendered over this long period of years signal service to the public welfare of this State; now, therefore,

Be It Resolved by the Senate of the State of New Jersey (the General Assembly concurring):

1. Congratulations and best wishes are extended to The Medical Society of New Jersey upon the occasion of its Two hundredth Anniversary and for the continued success of, and service to the citizens of New Jersey by, this important organization.

2. A copy of this resolution, signed by the President of the Senate and the Speaker of the General Assembly, and attested by the Secretary of the Senate and the Clerk of the General Assembly, be forwarded to John J. Bedrick, M.D., President of The Medical Society of New Jersey at Trenton, New Jersey.

Attest: *President of the Senate.*

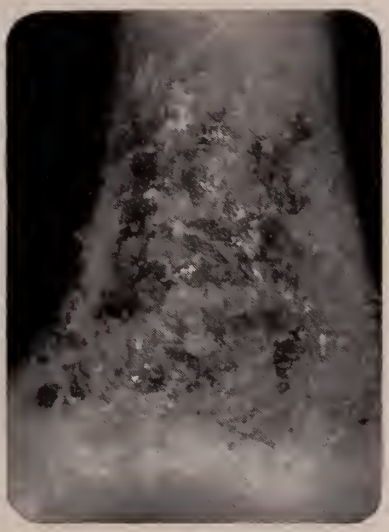
Secretary of the Senate.

Speaker of the General Assembly.

Attest:

Clerk of the General Assembly.

eczema: scourge of childhood



R. R., Age 11—Before treatment—atopic eczema of long standing



After treatment—with ARISTOCORT Topical Ointment 0.1% for two weeks

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Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Packages: Tubes of 5 Gm. and 15 Gm.; ½ lb. jar.

PHOTOGRAPHS COURTESY OF M. M. NIERMAN, M.D.

Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide
Also available in foam form and with neomycin.

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For prompt, emphatic diuresis

aquaTAG®
(BENZTHIAZIDE)



NEW FROM TUTAG for prompt, comfortable diuretic action with a balanced excretion of sodium chloride and a lower potassium loss under normal dosage and diet regimen

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease, advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or disfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

Before prescribing or administering, read the package insert or file card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.

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The BSP test, introduced in 1925, remains one of the most sensitive laboratory procedures available for determining hepatic function.

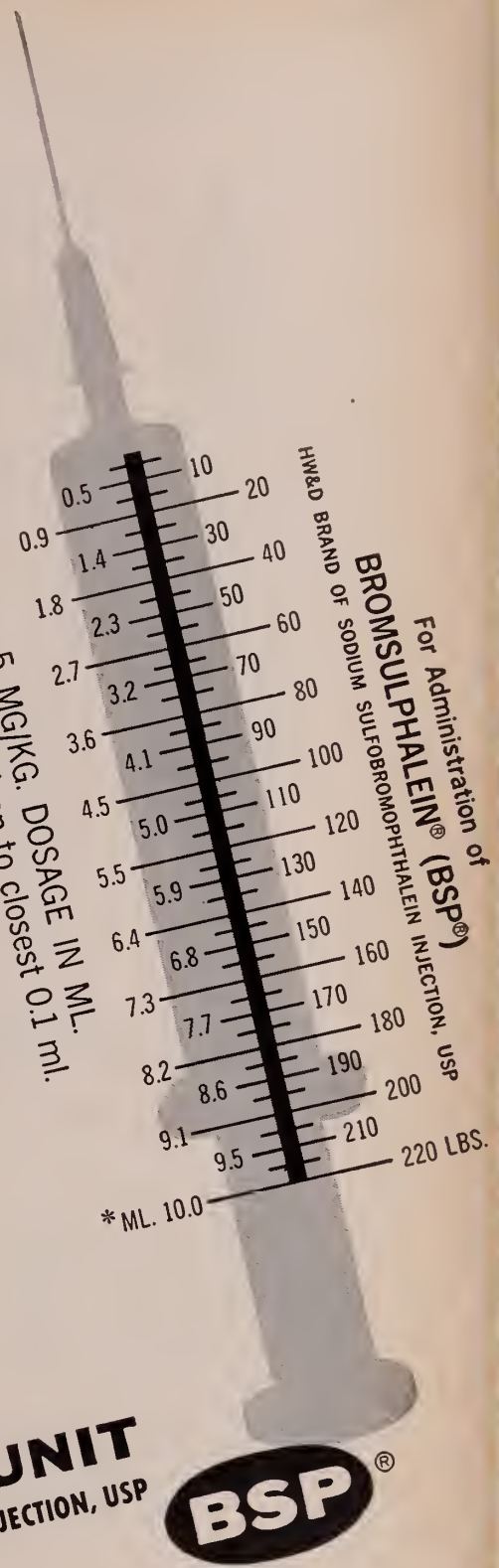
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Each BSP Disposable Unit contains: a sterile, glass, disposable syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of Bromsulphalein.

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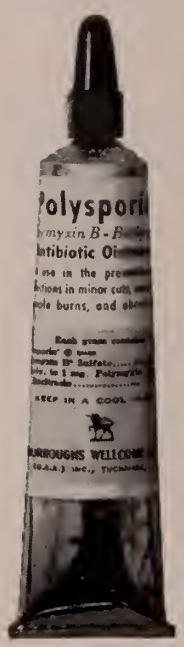
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broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Contraindication:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: In ½ oz. and 1 oz. tubes
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State Highway #35, Ocean Township, N.J. Eleven individual buildings of Colonial design, each with 1200 square feet of area or more. Individual privacy and separate entrances, full air-conditioning, gas heat and outdoor gas lighting are features, along with connecting walkways and more than 100 parking spaces. Ideally located in growing area, 10 minutes from Asbury Park and Long Branch, 15 minutes from Red Bank, Middletown. A new concept in professional office suites, this is located in the middle of a population of 250,000, by actual federal census.

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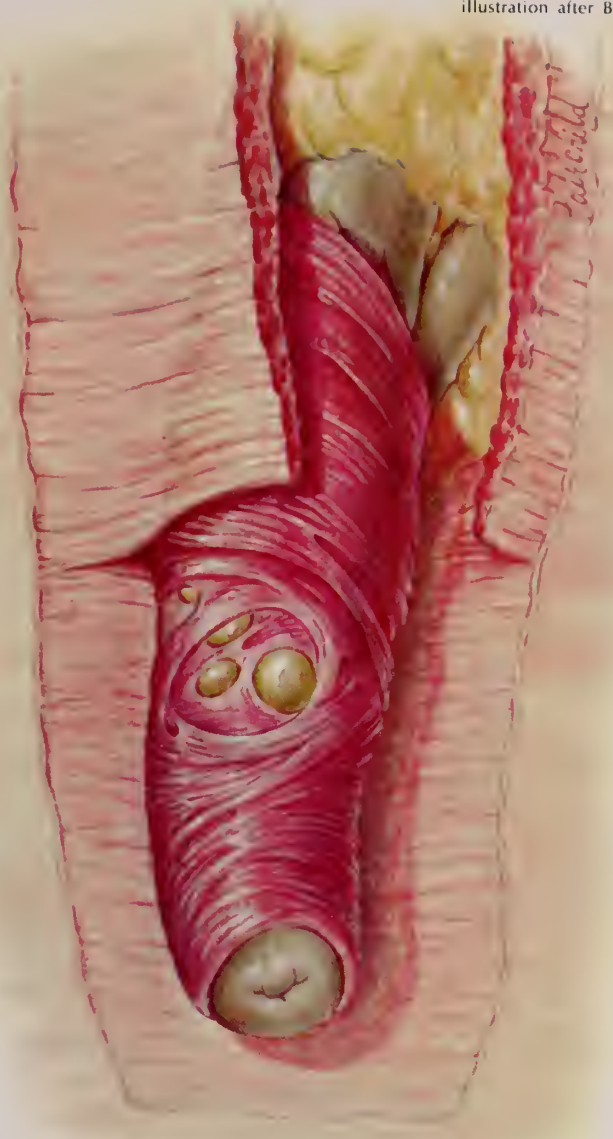
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illustration after Boyden



HOW IMPORTANT IS THIS

IN YOUR DIAGNOSES OF SMOOTH MUSCLE SPASM?

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PERHAPS VERY IMPORTANT

The sphincter of Oddi is made up primarily of smooth muscle fibers. It permits the gall bladder to fill, regulates the flow of bile and pancreatic enzymes and in dysfunction is a primary cause of Biliary Dyskinesia. The sphincter of Oddi is but one of five major foci of smooth muscle spasm where SPACOLIN® (Alverine citrate) acts directly with rapid onset and long duration. No neurotropic side effects because Spacolin is a musculotropic counter-spasmodic unrelated to atropine or atropine-like drugs. Spacolin is not contraindicated in prostatic hypertrophy.

SPACOLIN® (Alverine citrate)

Each tablet contains: Alverine citrate ..... 120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations. DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort. PRECAUTION: Caution is recommended when using in hypotensive patients. SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

*Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

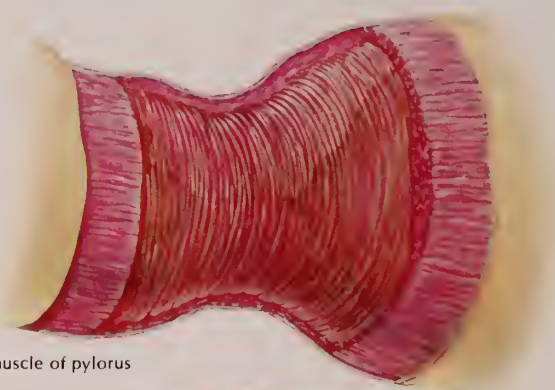
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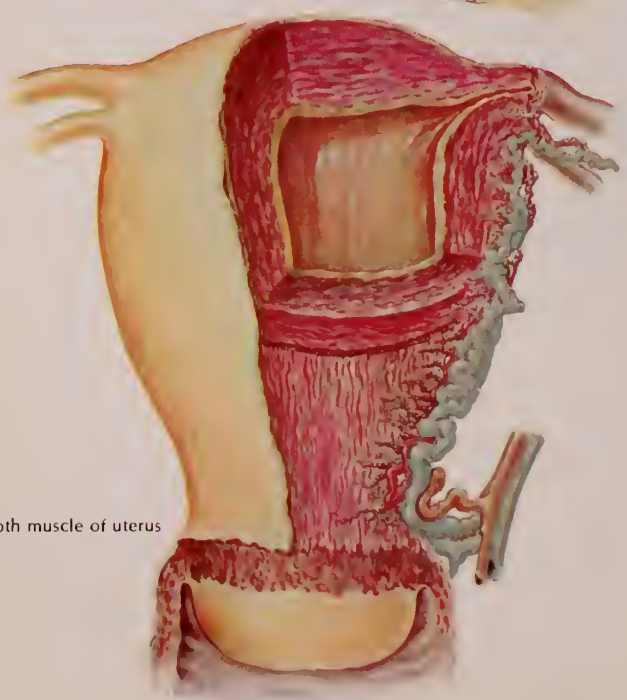
smooth muscle sphincter of Oddi



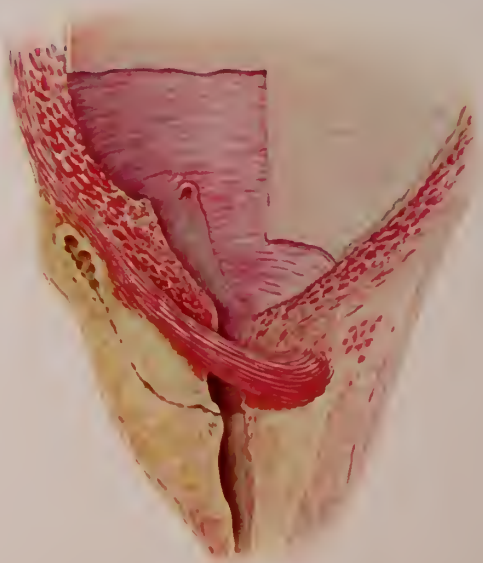
smooth muscle of colon



smooth muscle of pylorus



smooth muscle of uterus

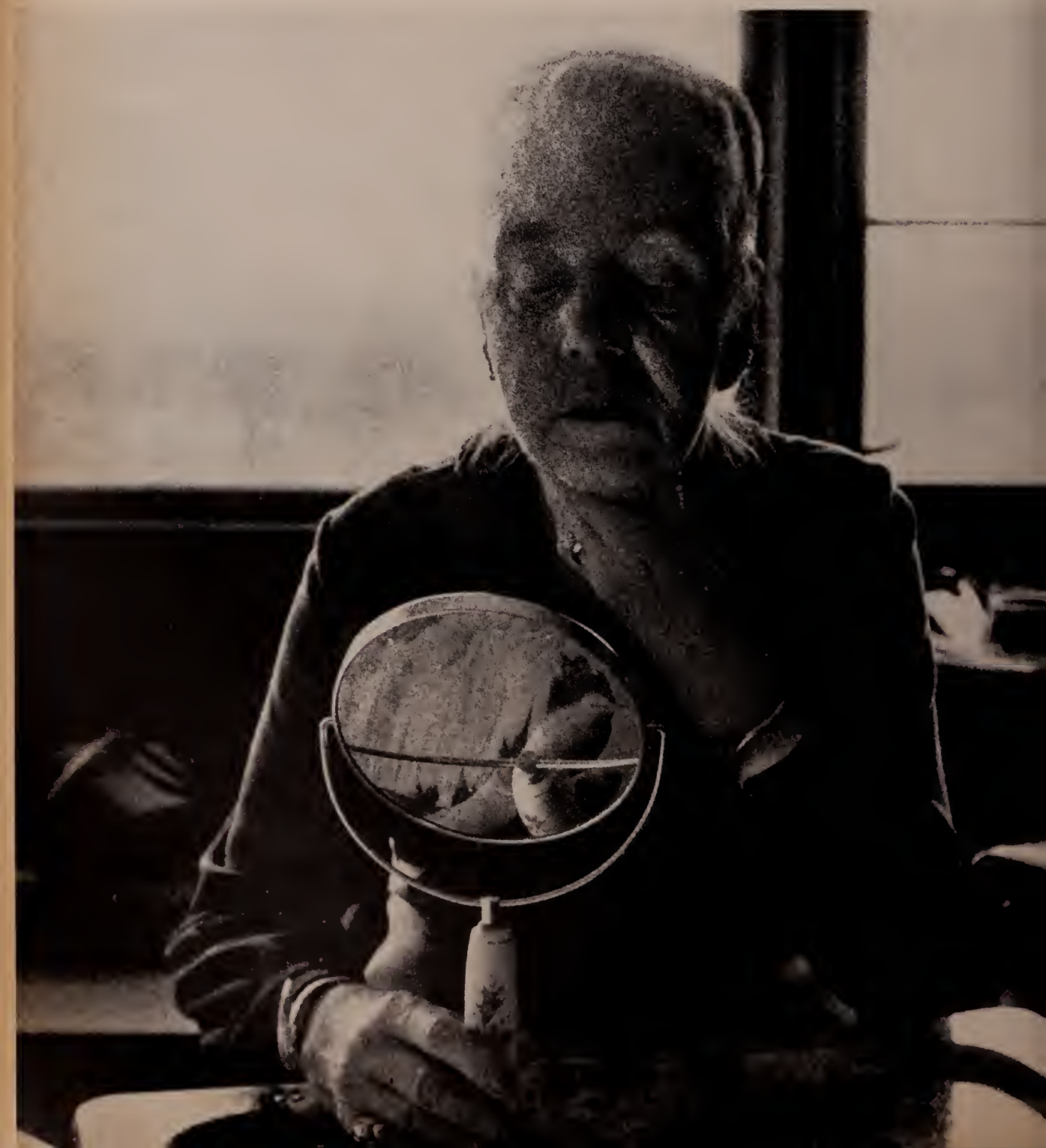


smooth muscle of urinary bladder

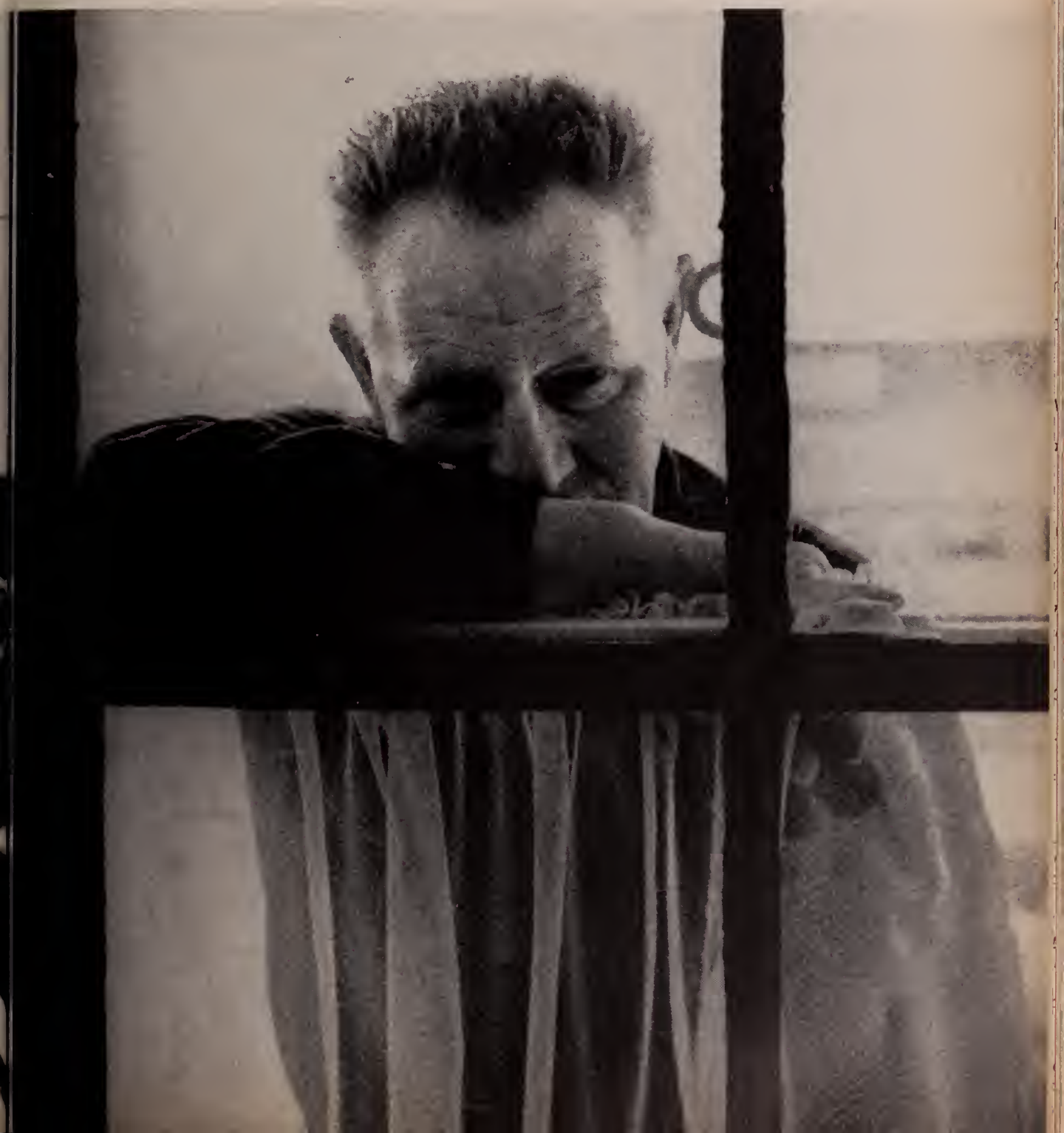
The Mediatric Age:
There is a growing senescent body of people who –either from lack of motivation, or as a result of surgery, trauma, or extended illness–are on their way to malignant inactivity...



The Mediatric Age:
Some may be not quite sick, nor yet quite well. They may complain of too easy fatigue, of vague aches and pains.
Many need your assurance that they are not as old as they feel...

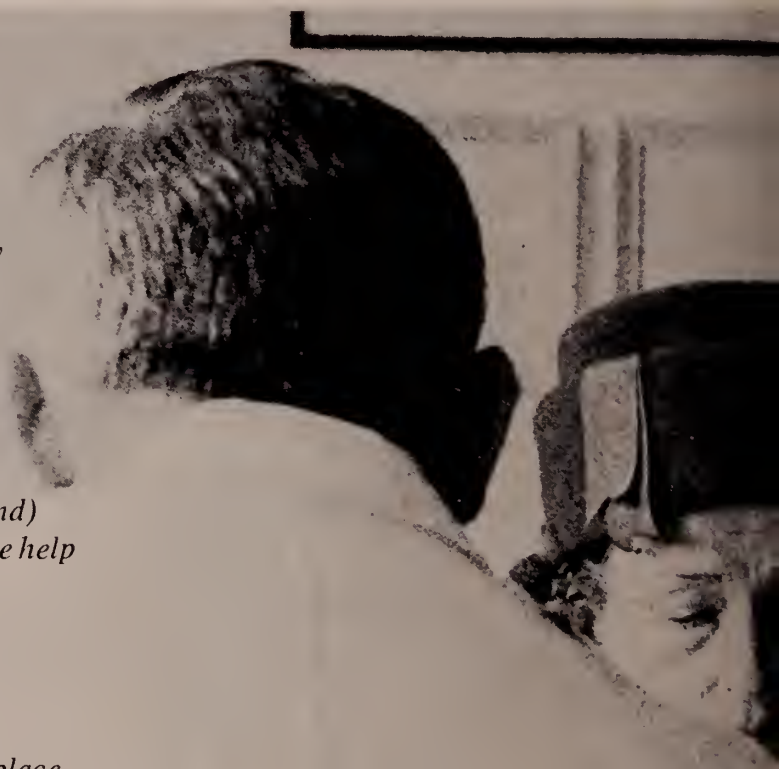


The Mediatric Age:
Frequently, they become "the waste-aways."
They have simply lost interest in
the maintenance of their own well-being—
often through the feeling
that they are no longer needed.



The Mediatric Age:

Unfortunately, there is no cure. But there are, largely through your own interest and direction, ways to help them back to a more active and useful life. There are medicines, too, designed to help. One such has proved useful in clinical practice:



"A steroid-nutritional compound (Mediatric) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging... This therapy resulted in improvement of 75 per cent of the patients..."

McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

"Mediatric (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied... The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.

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Nutritional reinforcement for those who can't – or won't – eat properly...balanced amounts of estrogen and androgen to counteract declining gonadal hormone secretion and its sequelae of premature degenerative changes...mild antidepressant for a gentle "mood" uplift...

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens—equine), the natural estrogen most widely prescribed for its superior physiologic and metabolic benefits.

MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation.* It contributes a *gentle "mood" uplift* through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

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Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic.	30.0 mg.
Methamphetamine HCl	1.0 mg.

*Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 910 – MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon. No. 752 – MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252 – MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.



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steroid-nutritional compound

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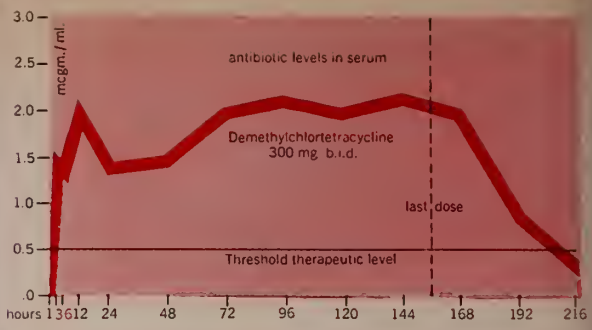
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greater potency

lower mg intake per day

600 mg versus 1,000 mg

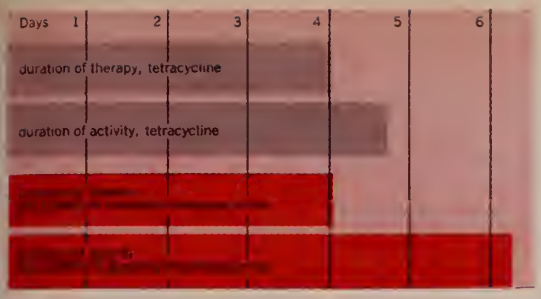


higher activity

levels than ordinary tetracyclines

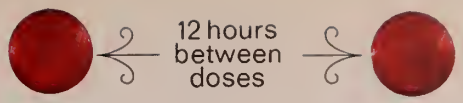
From Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.; Amer. J. Med. Sci. 243:296 (Mar.) 1962





1-2 days' "extra" activity

after the last dose to protect against relapse



one 300 mg Tablet
mid-morning

one 300 mg Tablet
mid-evening

It's made for b.i.d.

in G.U. infections
broad-spectrum performance above and beyond the activity of ordinary tetracyclines

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DEMETHYLCHLORTETRACYCLINE

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

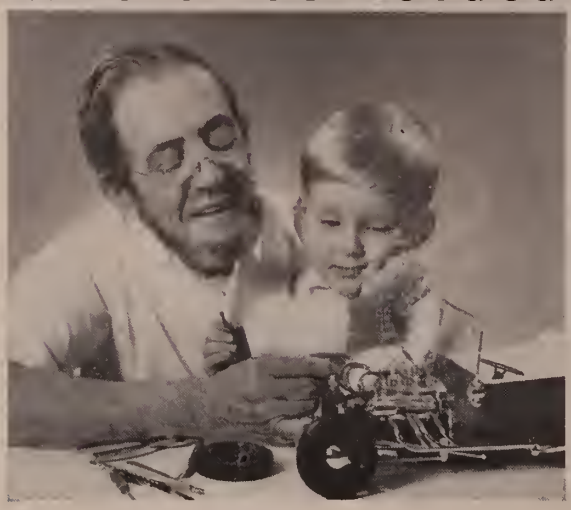
Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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Improvement of mental alertness and awareness in the management of the senility syndrome requires a comforting environment, a stimulating dietary regimen and concomitant drug therapy. LEPTINOL® is a non-addictive stimulant which is a useful adjunct in elevating the mood of the elderly patient who displays apathy, mental confusion or memory lapses.

LEPTINOL® is a combination of pentylenetetrazol, niacin, thiamin and ascorbic acid which acts as a central nervous stimulant and which exerts its primary effect on the mid-brain and the medullary center. LEPTINOL® may be prescribed for patients with mild hypertension or other organic diseases.

Each LEPTINOL® bi-layer tablet contains: PENTYLENETETRAZOL, 100 mg., NIACIN, 50 mg., THIAMINE HYDROCHLORIDE, 1 mg., ASCORBIC ACID, 20 mg. DOSE one or two tablets, 3 times daily.

Side Effects: overdosage may produce tremor, convulsions or respiratory paralysis.

Caution should be taken when treating patients with a low convulsive threshold. Patients should be warned not to exceed recommended dose which offers maximum effectiveness.

Write for detailed literature and starter LEPTINOL® doses.

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homatropine methylbromide	1.25 mg.

Usually works within 3 to 4 days in osteoarthritis

The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is *at least 1 month.*

That's why it's logical to start therapy with Butazolidin alka—you'll know quickly whether or not it works. And usually, it will.

A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile, or when other potent drugs are given concurrently. Large doses are contraindicated in patients with glaucoma.

Precautions
Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

Also available: Butazolidin®,
brand of phenylbutazone
Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
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A comprehensive residential program for children who cannot progress at a normal rate in a normal environment. A new diagnostic and rehabilitation center, Cooley Hall, recently opened, offering a comprehensive program in diagnosis, education, speech and hearing, and vocational rehabilitation. Several community services. Miriam R. Cooley, Director.

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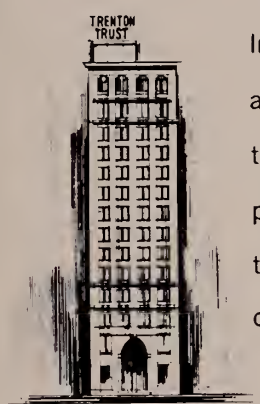
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CONTENTS • Pages 279 to 408

EDITORIALS

Edith Soden Madden, 1911-1966 279
The Agonizing Experimental Dilemma 280
Presenting: The Transactions 280

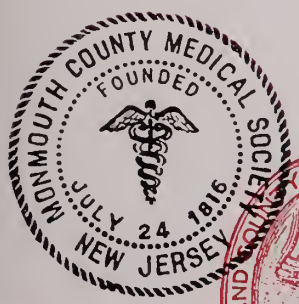
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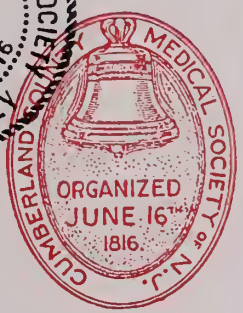
Index 281
Annual Reports 283
Resolutions 357
Reference Committees 375
Nominations and Election 390

ANNUAL MEETING

General Session 391
Medical-Surgical Plan 404
Attendance 408

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Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. *Contraindication*—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; *Tablets:* film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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Food is Strength. Food is Love.
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Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

ndications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

ide effects: Mainly mild, transient gastrointestinal disturbances; in ccasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild osinophilia, reversible subjective visual disturbances (overbrightness of ghts, change in visual color perception, difficulty in focusing, decrease in isual acuity and double vision), and reversible photosensitivity reactions. larked overdosage, coupled with certain predisposing factors, has produced rief convulsions in a few patients.

recautions: As with all new drugs, blood and liver function tests are advisble during prolonged treatment. **Pending further experience, like most hemotherapeutic agents, this drug should not be given in the first trimester f pregnancy. It must be used cautiously in patients with liver disease or evere impairment of kidney function.** Because photosensitivity reactions have ccurred in a small number of cases, patients should be cautioned to avoid nnecessary exposure to direct sunlight while receiving NegGram, and if a eaction occurs, therapy should be discontinued. The dosage recommended or adults and children should not arbitrarily be doubled unless under the areful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® leagent Strips or Tes-Tape® should be used since other reagents give a alse-positive reaction.

losage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times aily) for one to two weeks. Thereafter, if prolonged treatment is indicated, he dosage may be reduced to two Gm. daily. Children may be given pproximately 25 *mg. per pound* of body weight per day, administered in ivided doses. The dosage recommended above for adults and children hould not arbitrarily be doubled unless under the careful supervision of a hysician. Until further experience is gained, infants under 1 month hould not be treated with the drug.

low supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in ottles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on equest. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

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nalidixic acid

a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
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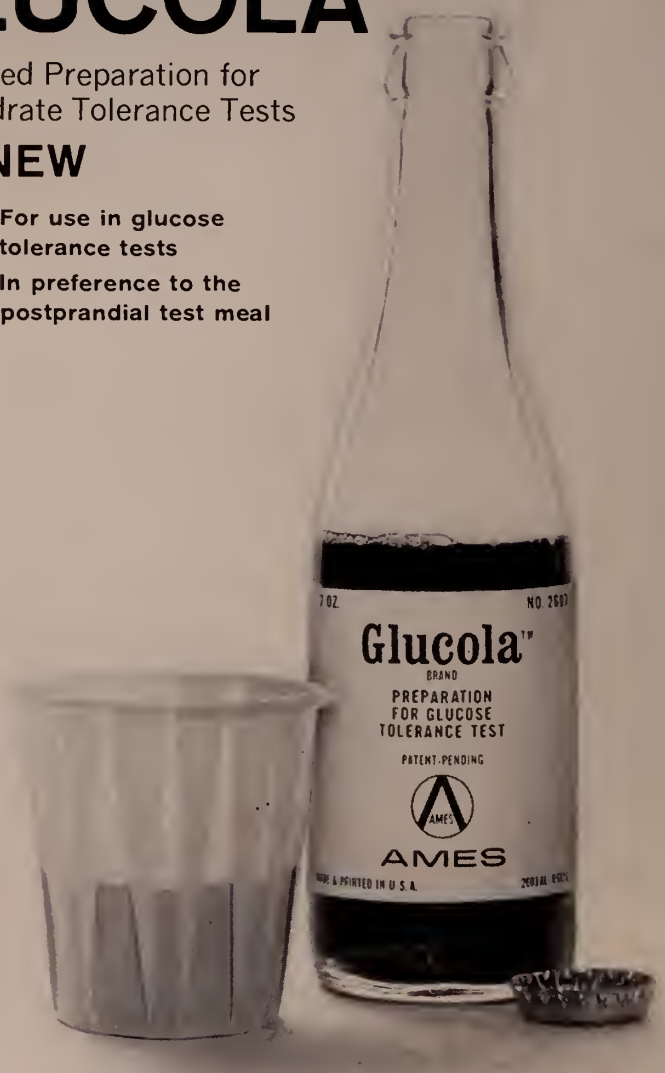
*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

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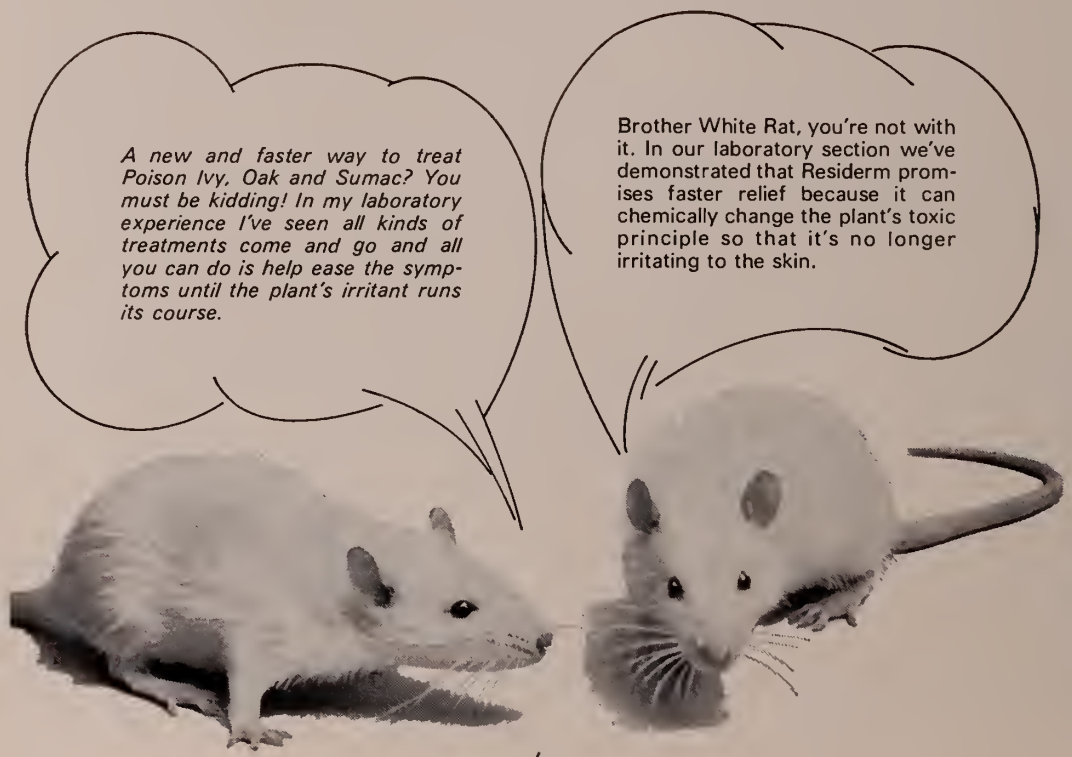
Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: 'Miltown' (meprobamate) is available in two strengths: 400 mg. scored tablets and 200 mg. coated tablets. 'Meprotabs' (meprobamate) is available as 400 mg. white, coated, unmarked tablets. *Before prescribing, consult package circular.*

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ADMINISTRATION AND DOSAGE: Directions for use: Shake the bottle. Apply liberally to the affected area with moderate rubbing and allow to dry. Allow film to remain on the skin for one-half hour, then wash area thoroughly with water and dry. Applications should be made three or four times daily.

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HOW SUPPLIED: Available as 1-3/4 fl. oz. in polyethylene bottles.

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summer 1966

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this issue: emergency anesthesia and the common cold

When emergency anesthesia is complicated by the common cold

Barry Belonsky, M.D., F.A.C.A.
Staff Anesthesiologist, Hospital of The Albert Einstein College of Medicine, New York City



Medical facilities are often presented with unfamiliar patients who have unknown health histories. This is particularly true in emergency situations that arise due to accidents or acute illnesses. These cases may need prompt care requiring anesthesia, and if they involve colds, nasal allergies or other upper respiratory infections, can account for many complications which make up a major hazard during emergency anesthesia.

Administration of general anesthesia to a patient with a cold or upper respiratory infection is a hazardous undertaking. It should be avoided if at all possible. Indeed, the presence of U.R.I. is good reason for postponement of elective surgery.[1] In emergency surgery, regional or local block should be considered, but if general anesthesia is mandatory, it should be approached with utmost caution.

Since the attitude of "emergency surgery — hurry" has been replaced by "emergency surgery — watch out",[2] a knowledge of the complications is a great help in preventing them. Here is a brief outline of the problems involved and their treatment. Prevention of the complications is discussed later.

Complications during the induction of anesthesia

Most of the complications are a direct result of secretions and some a result of accompanying secondary infection. For example, *airway obstruction* due to excessive secretions occurs very commonly and is the direct effect of the cold. Respiratory exchange may be obstructed at any time during anesthesia because of excessive secretions, but is most likely to occur during induction. Suction apparatus must be available to overcome this.[3]

Excess secretions which stimulate and irritate the epiglottis and vocal chords can cause *laryngeal stridor and obstruction*. This can lead to complete laryngeal closure with resultant anoxia and death.

Bronchospasm and laryngospasm can result fro secretions penetrating the bronchi and bronchiole In laryngospasm, there are both inspiratory and e piratory stridor and difficulty in inflating the ches in bronchospasm there is an expiratory wheeze, bu not as much difficulty in inflation, although som resistance may be felt. Stridor is due to partial c complete closure of the vocal cords in spasm and th "crowing" sound is almost pathognomonic.

Secretions obstruct the nasal airways. This produce *difficulty in ventilation* through the mouth until th patient is deep enough to place an oral airway. A intravenous agent can be given to facilitate the i duction of anesthesia.

Difficulties can arise if intubation is performed t ventilate the patient. For example, teeth can b broken by too vigorous attempts at intubation, o the intubation itself may be technically difficult du to secretions obstructing the view of the glottis. Th postoperative sequelae of intubation ranges fro mild laryngitis to pneumonia with atelectasis, an are seen far more commonly in patients sufferin from colds than in normal patients.



Successive stages of laryngospasm which produce the cha acteristic stridor or "crowing" sound.



Progression of bronchioles into bronchospasm.

Complications during the maintenance of anesthesia *Bronchospasm* can occur in an unintubated patient due to secretions entering the bronchial tree from above, and acting as an irritant to the bronchi and bronchioles. Secretions accumulate quickly and the patient has to be suctioned continually. The whole cycle of coughing, bucking, laryngospasm and bronchospasm may ensue. The difficult decision here is whether it is better to suction the patient continually or to use an endotracheal tube which protects the cords and bronchi but introduces the risk of attendant complications.

Postoperative complications Postoperatively, complications can be more serious than even the intra-anesthesia complications, and occur much more frequently in a patient who has been intubated.[4]

Sore throat and pharyngitis can result both from the preoperative upper respiratory infection and from the drying of the mucous membranes which occurs during anesthesia.

Tracheitis and bronchitis often result from secretions trickling down the tracheobronchial tree.

Laryngitis is frequently seen in patients with upper respiratory infections who have been intubated. There is a significant increase in the incidence of laryngitis compared to that in patients without upper respiratory infections.

Subglottic edema is a condition which occurs mainly in children who have been intubated. This pathology results from an exudate developing in the areolar tissue just below the cords. Because of the small size of the child's trachea, even a 1 mm increase in size of the mucous membrane can severely impair the air passage. Children exhibit this by severe expiratory stridor and may even become cyanotic. This may so severely embarrass the child's breathing that it must be treated vigorously. Most authorities agree on the treatment[5,6,7,8] consisting of a high oxygen concentration in the inspired air (60%), plus high humidity (close to 100%). Adequate parenteral fluid intake and slight cooling of the body temperature (by a cooled oxygen tent) also help in mild cases. In severe cases, there may be hypoxia which increases the restlessness and the oxygen demand rises. Sedation is often necessary, although concomitant depression of the respiratory center is undesirable. An antihistaminic accomplishes this purpose well, and adds sedation. Since there is always a possibility that an allergic response plays a role in edema, some relief of the respiratory distress may occur. Steroids should be used to control inflammatory and allergic phenomena and swelling. If all this fails, and the patient is still restless and hypoxic, a tracheostomy should be performed immediately.

(concluded on following page)



Your patient can breathe easily, flying from New York to Rome, on just one Triaminic timed-release tablet.

One tablet goes a long way. For 24 hour relief of nasal congestion and postnasal drip due to sinusitis, colds and respiratory allergies—simply prescribe one Triaminic timed-release tablet, swallowed whole, in morning, mid-afternoon and at bedtime.

Side Effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness, or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

Each **Triaminic**® timed-release tablet contains...

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

(Advertisement)



Cross section of trachea showing subglottic edema and lumen reduction due to mucous membrane congestion.

Pneumonia may also follow anesthesia administered to a patient with a cold. This can be caused by accumulated secretions becoming secondarily infected and causing consolidation of the lung. *Atelectasis* of the lung can result if one of the bronchioles becomes plugged by secretions, preventing aeration of the distal part of that lung. This is seen more frequently following upper respiratory infection because dry anesthetic gases aggravate the infection, causing secretions to change from watery to thick and viscid, and consequently difficult to suction.

Prevention of complications

The first rule to prevent complications, of course, is to use a regional or local anesthesia whenever possible. But when emergency surgery is a must, in spite of the presence of a cold, allergy, or upper respiratory infection, here are some ways to prevent complications.

Give nose drops preoperatively. This can help shrink the congested nasal mucous membranes and reduce secretions for better air passage. (Results of this method are sometimes unsatisfactory because of the short duration of effect or rebound congestion.) For longer effect, oral antihistamines with nasal decongestants are often given to provide and maintain a drying effect on secretions.

To clear the tracheobronchial tree, instruct the patient to cough preoperatively. Cold steam or water nebulizers effectively humidify the nasal, pharyngeal and bronchial passages and often make the patient more comfortable. Tenacious secretions become more watery under humidification, clear more thoroughly preoperatively and are more easily suctioned from the airway during anesthesia.

Give intravenous fluids to those patients who appear dehydrated due to a cold. In a well hydrated patient the respiratory tract secretions are less viscid and more watery. This is particularly true in asthmatics.

Summary

Administration of emergency anesthesia to a patient with a cold or upper respiratory infection can lead to a chain of events that may result in increased postoperative morbidity and even death. This is because of the excess secretions formed in these conditions. Preoperative measures to prevent or reduce these secretions should be undertaken and will result in smoother and safer anesthesia.

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Dosage: Adults—2 teaspoonfuls; Children 6 to 12 years—1 tsp.; Children 1 to 6 years—½ tsp. Administer every four hours. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness, or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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Behind continued high blood pressure readings lies the possibility of organic damage[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.



"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,[15-17] since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

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Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weignt gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

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So I said, "All right, Raymond, if you don't take your cough medicine this minute, I'll call Doctor Peabody."

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Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.

Each 5 ml. teaspoonful of Novahistine DH contains codeine phosphate, 10 mg. (Warning: may be habit forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, 2 mg.; chloroform (approx.), 13.5 mg.; l-menthol, 1 mg. (Alcohol 5%). Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

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chlorthalidone 50 mg. reserpine 0.25 mg.

1 tablet daily brings pressure down

Advantage: Both components of Regroton are long-acting.
Average dosage: One tablet daily with breakfast.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs. With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.
Availability: Bottles of 100 and 1000 tablets.

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Thanks to Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

she can say "No thank you" to the crêpes suzette.

'Dexamyl' does more than most anorectics. Because it curbs appetite *and* lifts mood, 'Dexamyl' can encourage the discouraged dieter to stay on her diet.

The mood lift with 'Dexamyl' can make the difference between the success or failure of her diet plan.

Formulas: Each 'Dexamyl' Spansule® Capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

Before prescribing, see SK&F product Prescribing Information.

Smith Kline & French Laboratories SK&F



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TABLETS & GRANULES

for fever blisters and canker sores of herpetic origin

LACTINEX contains a standardized viable mixed culture of *Lactobacillus acidophilus* and *L. bulgaricus* with the naturally occurring metabolic products produced by these organisms.

LACTINEX was introduced to help restore the flora of the intestinal tract in infants and adults.[1,2,3,4]

LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.[5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

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HW&D

BALTIMORE, MARYLAND 21201

(LX03)

References: (1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

LX

SOME HELPFUL REMINDERS

. . . on Blue Shield Complementary Coverage under Medicare Part B

It will save time and trouble for you . . . your Medi care patients . . . and Blue Shield . . . if the following points regarding Blue Shield Complementary Cover age are kept in mind:

Blue Shield cannot act on a claim for Complemen tary benefits until the Part B carrier has paid the Medicare portion of charges.

Hence any claim for Complementary benefits mus be accompanied by the "Explanation of Benefits' furnished by the Part B carrier to the patient, show ing the Medicare payment.

THE "65 PROGRAM"—"Blue Cross and Blue Shield 65' program covers in-hospital services only. For these it pays the $50 annual deductible (or any part in curred for in-hospital services) and the 20 percen balance of the physician's reasonable charges, as determined by the Medicare Part B carrier.

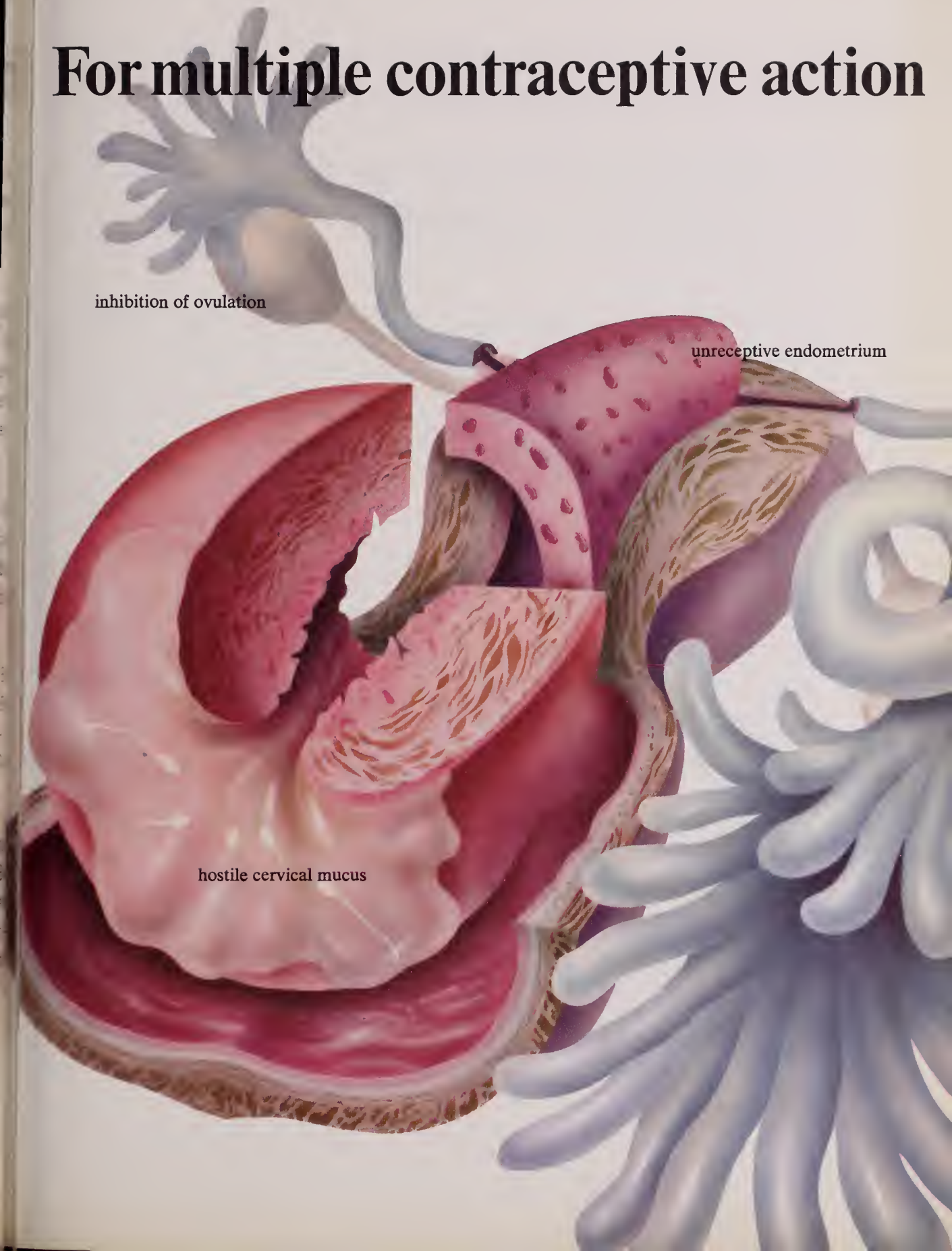
"CARVE-OUT" PROGRAMS—The other Blue Shield Com plementary Programs, known as "carve-outs," cove the difference between the Blue Shield schedule allowance (or the physician's charge, if less) and the payment made by the Medicare Part B carrier.

All services which are eligible under the basic Blue Shield Subscription Certificate, as well as any Blue Shield Riders held, and which are also eligible fo Medicare benefits, are covered for Blue Shield Com plementary "carve-out" benefits.

ADDITIONAL SERVICES COVERED — In addition, Comple mentary "carve-out" programs include special Blue Shield coverage for services personally rendered and billed for by "hospital-based" specialists — radiologists, pathologists and physiatrists — which have been traditionally covered by Blue Cross as hospital services.

BLUE SHIELD ®
MEDICAL-SURGICAL PLAN OF NEW JERSEY
500 Broad Street, Newark

For multiple contraceptive action



Norinyl® tablets

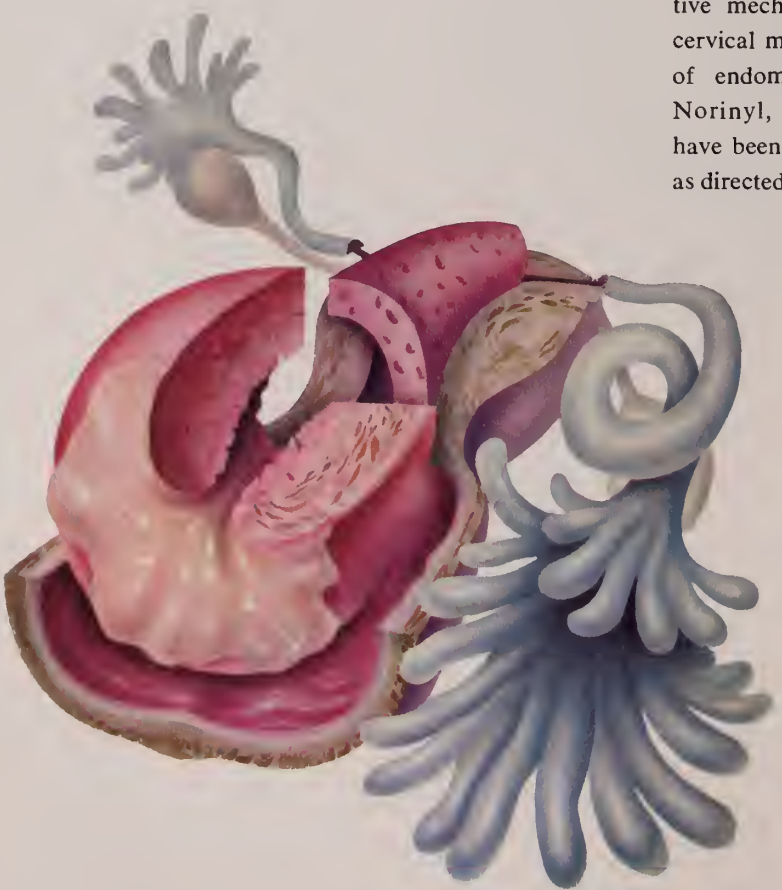
(norethindrone 2 mg. c mestranol 0.1 mg.)

multiple action that has produced a record of unexcelled effectiveness

inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

creation of an endometrium unreceptive to egg implantation



no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects

Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage

An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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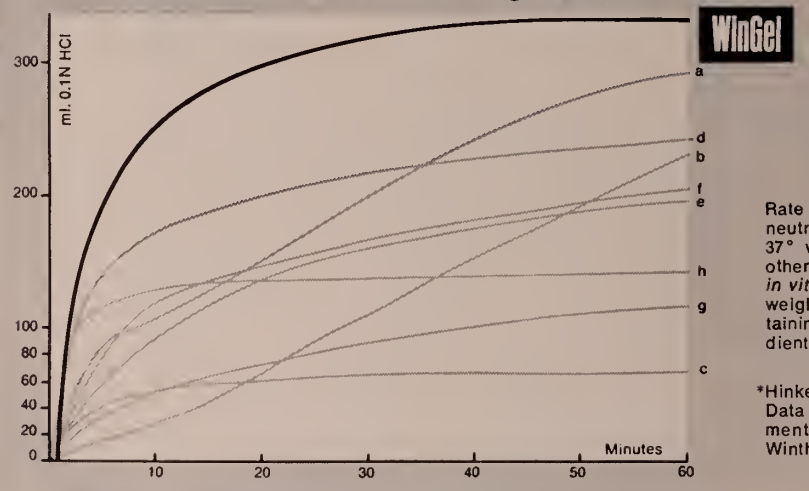
Neutralizes 300 times its active-ingredient weight in gastric acid for fast, long-lasting relief

Gastric or duodenal ulcer, acute or chronic gastritis, gastric hyperacidity...wherever there is "acid overflow" new WinGel can provide faster, longer, more complete neutralization.

In recent laboratory comparisons* with eight other leading antacids, new WinGel tablets not only neutralized more hydrochloric acid per active-ingredient weight, but neutralized it faster and longer than all other antacids tested.

Pleasant pink in color, WinGel is delicately mint flavored with a smooth-as-cream texture—qualities sure to please the patient on long-term therapy. New WinGel is also specially formulated to avoid constipation or diarrhea.

New WinGel neutralizes 300 times its active-ingredient weight in 0.1N hydrochloric acid—neutralizes more acid faster than other leading antacids



Rate of 0.1N hydrochloric acid neutralization at pH 3.5 and 37° with WinGel and eight other leading antacid tablets—*in vitro*. Samples equaled the weight of tablet material containing 1.0 Gm. active ingredients.*

*Hinkel, E. T., Jr. (New York): Data in the files of the Department of Medical Research, Winthrop Laboratories.

Dosage: Peptic ulcer or gastritis—from 2 to 4 teaspoons of WinGel liquid or 2 to 4 tablets chewed or allowed to dissolve in the mouth every two to four hours. **Gastric hyperacidity**—2 tablets or teaspoons about ½ to one hour after meals as needed; children from 7 to 14 years of age, 1 or 2 tablets or 1 or 2 teaspoons of liquid as needed.

How Supplied: Liquid in bottles of 8 fl. oz. and 1 pint **Tablets** in cellophane strips, boxes of 50 and 100. (One teaspoon of WinGel liquid is equivalent to one WinGel tablet in acid-combining capacity.) WinGel, trademark reg. U.S. Pat. Off.

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(1058M)



the sedentary life is often the seat of low back pain

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

SOMA®
(CARISOPRODOL)

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Eczema of many years... controlled in two weeks



Before treatment



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Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

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Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide
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this new code could save your patient's life

(see previous page)

EDITORIALS

Edith Soden Madden 1911-1966

In her years of service, Edith Madden was the senior member of our Medical Society's staff. She first came to work for us in 1933 when Fred Quigley was our President and when the whole complex structure of The Medical Society of New Jersey was housed in a small three-room suite in a bank building on East State Street. She was Edith Soden then—22 years old, eager to please, but expecting to work for just a few years. She certainly did not then know that she would swiftly climb every step of the staff ladder, to become, before long, the chief of staff of the office force, and eventually the major link between our Society today and our Society then.

A 1929 alumna of the Trenton High School, she did graduate work at Rutgers in New Brunswick, and then was employed in the office of the Board of Education in Trenton. When the Medical Society's headquarters moved from the Secretary's hat to its own office in 1933, Edith finished first in the little examination that Leroy Wilkes had developed for job applicants.

She married John Madden, an engineer in the State Highway Department, in 1938. The Maddens had only one child—Thomas Michael. In the Medical Society office we always called him Timmy. Timmy was killed in an automobile accident in 1960, and as might be expected something irreplaceably precious went out of his mother's life on that day.

But Edith carried on. She was, in the meaningful sense of that overworked word, a "trooper." She got to every nook and cranny of State Medical Society activities. She learned more about organizing a state-wide convention than most of us could learn in a lifetime. If anybody had any question about medical society structure or convention details, Edith was the answer girl. Since 1933, our Society has had three executive officers, four secretaries, 32 Presidents, but only one Edith Madden. In the internal affairs of our Society, she ran a tight ship. She was efficient, fast, fair, knowledgeable, and, we used to think, indestructible. In 1961 we sang "Happy Birthday" to her as she reached the age 50, and we looked forward to 15 or 20 more years of her service. Edith's birthday, May 15, usually came during our Annual Meeting—and this year's convention just didn't seem the same without her guidance, indeed without even her presence. By that date we knew (and we think Edith did, too—but she was a gallant one and didn't show it) that her days were numbered.

At a recent meeting of the Board of Trustees of our Society, the following resolution was adopted:

Whereas, God in His wisdom has seen fit to summon Edith Louise Madden to her eternal reward; and

Whereas, in almost thirty-three years of continuous, diligent, and devoted service—culminating in her work as Administrative Secretary and Convention Manager — Mrs. Madden contributed to the growth and attainments of The Medical Society of New Jersey; and

Whereas, in consequence she has won an enduring place in the history of the Society and in the hearts of its members; now therefore be it

RESOLVED, that The Medical Society of New Jersey records its profound grief at her passing; and be it further

RESOLVED, that a copy of this resolution be placed in the archives of the Society, and that a further copy thereof be delivered to the husband and family of Mrs. Madden as an expression of heartfelt sympathy in their bereavement.

As Bailey put it, "We bow our heads at going out and enter straight another golden chamber, larger and lovelier than the one we leave." And somewhere in that larger and lovelier chamber, Edith must still be worrying about our Society. And we below can pay her now only this last tribute: to say a final and a fond farewell.

The Agonizing Experimental Dilemma

The agonizing ethical dilemma of medical research has been lighted up by several recent difficulties. To determine whether foreign cancer cells would arouse immunologic protection in weakened subjects, one experimenter injected live cancer cells in patients free of malignancy. None of the patients "caught" the cancer. Still, it seemed like a risky experiment, and the families of the subjects would probably not have consented if told that the proposal was to inject "live cancer" cells. In another project, desperately sick patients were divided into two groups: one getting, one being denied a drug that had previously shown its effectiveness. At some point in every drug research, the investigator must switch from experiments on animals to administering the drug to humans. And some person must be the first human being ever to get the new medication. A new surgical approach may be done a hundred times on dogs or monkeys. But sooner or later, a human being must be the subject.

If experiments like these are not done, medical research grinds to a halt. But if they *are* done, the investigators are on the horns of a serious ethical dilemma. It is all very well for lawyers to say that the propriety of the procedure turns on "informed consent." This is easier said than done. Sound experimental technic requires the matching of the subjects getting the drug with an equal number getting a placebo. How do you get informed consent to receiving a placebo? Even if you got it, the fact that the patient knew he was getting an inert drug would contaminate the experiment. And how do you explain the pharmacologic actions, the possible untoward effects on various body systems, and the unknown long range metabolic changes — how do you explain this to a medically unsophisticated subject? The most urgent research needs are in the area of the most serious diseases. Can you get the victim of such a disease to agree to a procedure solely for the sake of science, in the abstract? Sometimes, of course, the ethical problem is solved by the patient who demands that the doctor try anything no matter how dangerous it is, if there is any chance that it might help. Usually, however, it is not that easily resolved.

One of the changes brought about by the increasingly *scientific* aspects of medicine (with, too often, a decrease in humanitarian, compassionate, and subjective components) has been the development of a medical researcher with a terrific drive to know. Sometimes the satisfying of this intellectual curiosity becomes an end in itself. We do need research investigators powered by such curiosity. But we must somehow find one to supervise such projects who can say where intellectual curiosity ends and human compassion begins.

Presenting: The Transactions

In this issue you receive a compact record of your Society's work for 1965-66. Called *The Transactions,* this reflects the parliament of New Jersey medicine. The scientific work of the Society is made known to you through articles in past and future issues of this JOURNAL. But the administrative and organizational activities of The Medical Society of New Jersey are highlighted in *The Transactions.* Not every member gets to Atlantic City. And while every one who does is welcome to sit in on meetings of the House of Delegates, the fact is that most members just don't take advantage of that opportunity. So this is your one annual chance to see the wheels go round. The *Transactions* accurately reflect the long and the short and the tall; the commendations and the condemnations; the good, the bad, and the indifferent; the carefully thought out remarks and the off-the-cuff (sometimes the "hot-under-the-collar") comments. Here it is now, our unexpurgated version of the annual business meeting: New Jersey's organized medicine in action. Read it!

200th ANNUAL MEETING
Haddon Hall, Atlantic City
MAY 14-18, 1966

Official Transactions Of the House of Delegates

THE MEDICAL SOCIETY OF NEW JERSEY

NOTE TO READERS

The annual reports and transactions of the House of Delegates of the 200th Annual Meeting of The Medical Society of New Jersey are bound together in this issue of THE JOURNAL. Actions taken by the House of Delegates are indicated in bold-face small type.

INDEX

	Reference Committee	Page
Academy of Medicine of New Jersey	"B"	299
Air Pollution Control	"G"	297, 333
Alcoholism, Establishment of Special Committee on, Resolution #7	"G"	362
AMA National Programs	"E"	295
AMA Proposed Membership Dues Increase	"A"	298
Animal (Medical) Research	"E"	299
Annual Meeting	"H"	305
Approval by Individual Diagnosis (AID) Program	"C"	295
Discontinuance of AID Program, Resolution #4	"C"	359
Armed Forces Dependents' Medical Care Program	"C"	350
Bicentennial History	"H"	298
Board of Trustees	"A"	291
Cancer Control	"G"	334
Child Health	"G"	335
Chronically Ill and the Aging	"F"	331
Committee Structure	"A"	291
Compensation of Physicians for Care of Subsidized Patients, Resolutions #5, #6, #12, #18	"F"	360, 361, 366, 371
Conservation of Hearing and Speech	"G"	337
Conservation of Vision	"G"	337
County Judicial Committees	Const. & Bylaws	321
County Presidents, Conference of	"A"	292
Credentials	"A"	307
Disaster Medical Care	"H"	343
Discrimination in Admission to Membership	"A"	298
Resolutions #1, #10, #13	"A"	357, 364, 367
Emeritus Membership, Nominations for	"H"	356
Ethics of Individual Responsibility, Resolution #16	"F"	369
Executive Director	"A"	302
Finance and Budget	"B"	308
Health Care of the Aged	"F"	296
Health Facilities Planning Council	"F"	297
Heart Disease, Cancer, and Stroke	"G"	297
Honorary Membership	"H"	310
Hospital-Based Specialists	"F"	297

	Reference Committee	Page
House of Delegates' Meeting Schedule, Resolution # 9	"H"	363
Special Meeting of	"A"	292
Individual Responsibility Program, Resolution #19	"F"	372
Interns and Residents, Payment of	"C"	294
JEMPAC	"E"	296
Judicial Council	"A"	300
Legislation	"E"	322
Liability Panel, Professional	"A"	291
Maternal and Infant Welfare	"G"	338
Medical Defense and Insurance	"D"	311
Medical Education	"D"	314
Medical School Facilities, Expansion of, Resolution #17	"F"	370
Medical Services	"F"	329
Medical Student Loan Fund	"B"	315
Medical-Surgical Plan	"C"	345
Board of Trustees Nominations	"C"	293
Contract Inequities	"C"	293
Non-Assignment Policy	"C"	295
Medicare, Cooperation with, Resolution #11	"A"	365
Medicare Law	"F"	296
Medicine and Religion	"D"	343
Mental Health	"G"	338
Committee Structure	"G"	297
Community Centers	"E"	295
MSNJ in Action	"A"	303
Nursing Education and Recruitment	"H"	344
Occupational Health, Rehabilitation, and Workmen's Compensation	"F"	331
Osteopathy, Drafting Fully Licensed Doctors of, Resolution #2	"A"	358
President	"A"	283
Project Hope, Resolution #3	"B"	358
Publication	"B"	318
Public Health	"G"	332
Public Relations	"E"	339
Personnel	"A"	292
Reference Committees:		
"A"		375
"B"		378
"C"		379
"D"		381
"E"		382
"F"		383
"G"		385
"H"		387
Const. & Bylaws		389
Resolutions		357
Retirement Plan for Physicians	"D"	344
Revision of Constitution and Bylaws	Const. & Bylaws	320
Safety Lenses in Children, Use of, Resolution #8	"G"	363
Scientific Exhibits	"H"	307
Scientific Program	"H"	306
Secretary	"A"	284
Separation of Professional Fees and Hospital Charges, Resolution #15	"C"	368
Traffic Safety	"H"	344
Treasurer	"B"	285
Urging Creation of Top-Level Health Care Groups, Resolution #20	"F"	373
Urging Passage of Implementing Legislation for Title XIX, Resolution #21	"F"	374
Woman's Auxiliary Advisory	"H"	319

ANNUAL REPORTS

President

John J. Bedrick, M.D., Bayonne
(Reference Committee "A")



The presidential year is long in anticipation but short in passing. The reason is, I think, because it is so busy, so demanding, so interesting, and so satisfying. At least it has been for me.

It has been a great honor to me to serve as the one hundred and seventy-third president of The Medical Society of New Jersey, and to have held that office in this the bicentennial year. The experience has deeply impressed, enlightened, and enriched me. I have enjoyed it very much.

The Medical Society of New Jersey is a busy organization. It has commitments, connections, committees, and activities almost beyond count. It is responsive to its obligations and duties to a high degree. At all levels — from the Board, through councils, committees and staff — it is dedicated, zealous, and efficient. As one who knows whereof he speaks, I can assure you that it has been a real pleasure to share in the work of the year, and to participate in, and benefit from, the clear thinking and purposeful action that have consistently characterized our Society's operations.

One of the occult compensations of the presidency is the opportunity to visit around the state, and to meet and mingle with the members of our component societies. Everywhere I went and everyone with whom I came in contact was most gracious and courteous. It was encouraging to me to find how common are the problems which confront us, and how balanced the judgment and how uniform the reactions of all to the changing circumstances of these changing times. It is universally recognized that our profession is face to face with pressing changes, many of which pose more hazard than hope. But likewise it is recognized that the realities of these changes must be acknowledged, and that — firm in adherence to our basic principles of service to our people and our profession — we must exercise sufficient flexibility to enable us to consider proposed changes, on the basis of merit rather than preconception or bias, as long as those proposed changes do not violate our basic principles.

It is also generally accepted that, even though it means more work and sacrifice, it is better that the maintenance of standards or professional practice and of ethical behavior be retained as a responsibility exclusively in the hands of members of the medical profession. Physicians have created and developed the structure of medical practice. It is natural and right that they should wield responsibility over it. It would be unnatural and wrong for others to do so, but we should bear in mind that if the members of the profession shirk the responsibility of wielding that control, others less able are all too willing to take it over.

As your president, I have visited a number of other states as the official representative of The Medical Society of New Jersey. In every instance I was treated with respect and friendliness that were not bestowed as my personal due, I know, but that were given as a demonstration of the regard and good will that our sister state societies hold for our Society and for all of you.

I offer now my heartfelt thanks to all for the distinctions and the satisfactions that I have enjoyed as president of our great Society. I offer my thanks especially to those with whom I worked intimately—to my fellow officers and to our splendid staff. And let me say that in my opinion that staff could not be more competent, more diligent, more loyal, or more painstakingly industrious. I leave the office with memories that will long be a source of genuine delight, and with a heart that will be ever grateful.

For two hundred years members of The Medical Society of New Jersey, inspired by a worthy idealism and endowed with a great capacity for high and distinguished service, have been meeting and overcoming the challenges of their times. Their success has been outstanding. Let it give courage to all of us to face the life of our times without doubt or fear of any kind. The pattern is there for us to follow. Let us get on with the work.

Approved (page 375)

Secretary

Marcus H. Greifinger, M.D., Newark
(Reference Committee "A")



The office of the Secretary has continued its usual routines, primarily involving correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the annual meeting of the American Medical Association in New York and the Clinical Meeting in Philadelphia — serving in a dual role as the Secretary and an AMA Delegate. At state level, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

AMA Membership

6,109 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates continued to total seven delegates — one for each thousand members, or fraction thereof.

MSNJ Membership

(As of December 31, 1965)

Active: Paid	6,401	
Exempt	400	6,801*
Associate: Paid	389	
Exempt	41	430*
State Emeritus		182
State Honorary		5
New and Reinstated Members:		
Active	179	
Associate	244	423
Transfers within the state		22
Transfers out-of-state and resignations		32
Members deceased		67
Members dropped:		
Active (non-payment of dues)	33	
Associate (non-payment of dues)	13	46

* Adjusted for Transfers Out-of-State Resignations, and Deaths.

Membership Directory

Work is being carried forward to achieve the publication of the next edition of the *Membership Directory* in the fall of 1966. At this time it is expected that distribution will be made to the entire membership.

The committee agreed to the following: (1) That the format of the 1964-65 *Directory* be used for the 1966-67 *Directory,* with a marginal index to identify the twenty-one counties within the geographical section of the *Directory;* (2) That the "type of practice," in the individual listing, directly follow the name, prior to the address, and that it be in bold print with a box-effect square surrounding it; (3) That a symbol (asterisk), be used to designate "Armed Forces," as the single dagger (†) is now used to designate associate, and the double dagger (††) is used to designate emeritus memberships; (4) That the hospital section of the *Directory* include the staff listing of proprietary hospitals, heretofore not carried; and (5) That in the special membership supplement section, which now includes the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Legal Hazards of Medical Practice in New Jersey, and a list of Poison Control Centers in New Jersey – there also be included, the Basic Concepts Underlying Provision of Professional Medical Care; and any new laws affecting medical practice or medical practitioners.

Informational data sheets supplied to the membership will form the basis for the biographical data to be published in the 1966-67 edition, as did the questionnaires which were supplied to publish the 1964-65 *Directory.* With the cooperation of the membership, it is the hope of your committee to make this forthcoming *Directory* the most complete and accurate edition yet published.

Approved **(page 376)**

Treasurer

Daniel F. Featherston, M.D., Asbury Park
(Reference Committee "B")



This 1966 interim report of your Treasurer has been prepared from the books and records of MSNJ by the Society's outside auditors.

The Balance Sheet is presented as of April 30, 1966 without audit or verification, because the current fiscal year of MSNJ does not end until May 31, 1966. Audited figures and a complete report of audit will be prepared and submitted for the fiscal year ended May 31, 1966.

The Statement of Cash Receipts and Disbursements has been prepared, without audit, on a cash basis and does not purport to show the results of operations for the period indicated.

The Statements of Receipts and Disbursements cover the cash transactions in the office of the Treasurer for the twelve months from May 1, 1965 to April 30, 1966. This period comprises one month of the 1964-65 fiscal year and eleven months of the current fiscal year and is so presented in conformity with the suggested form of prior years.

Cash receipts were checked by the auditor in full for the period and disbursements checked to supporting vouchers. The cash balances at April 30, 1966 were reconciled with the bank statements but were not confirmed direct with the depositories. Receipts from counties for dues' assessments were checked in detail to reports on file, but were not confirmed with the county treasurers at this time.

BALANCE SHEET, APRIL 30, 1966
GENERAL FUND

ASSETS

Cash:		
First Trenton National Bank:		
General Checking Account	$90,816.19	
Executive Office Revolving Account	12,500.00	$103,316.19
Savings Accounts:		
The Bank of Commerce, Newark	$10,000.00	
Bloomfield Savings Bank, Bloomfield	10,000.00	
Broad National Bank, Newark	10,000.00	
First Camden National Bank and Trust Co.	10,000.00	
First Merchants National Bank, Asbury Park	10,000.00	
First National Bank of Stone Harbor	10,000.00	
First National Bank of Westville	10,000.00	
The Howard Savings Institution, Newark	10,000.00	
The Morris County Savings Bank, Morristown	10,000.00	
The Montclair Savings Bank, Montclair	10,000.00	
Plainfield Trust Company, Plainfield	10,000.00	110,000.00
Savings and Loan Accounts:		
Guardian Savings and Loan, Atlantic City	$10,000.00	
Midtown Savings and Loan, Newark	10,000.00	
Monroe Savings and Loan, Newark	10,000.00	
Police Savings and Loan, Newark	10,000.00	
Roma Savings and Loan, Trenton	10,000.00	50,000.00
Total Cash		$263,316.19
Accounts Receivable—Journal		6,301.32
Inventory—Maternal Welfare Records Books (contra)		1,043.75
Investments—U. S. Savings Bonds and Treasury Bills		221,529.46
Land, Buildings and Equipment (contra)		156,665.69
Accrued Interest on Investments		1,936.77
Total Assets		$650,793.18

LIABILITIES, RESERVES, AND SURPLUS

Accounts Payable	$ 888.39
Unexpended budget—1965–66 Fiscal Year	51,996.88
Employees Payroll Deductions Payable	2,172.67
Assessments Deferred to the 1966–67 Fiscal Year	147,685.04
Bicentennial Fund	16,106.34
Library of Academy of Medicine Fund	8,578.75
AMA Dues Payable	6,750.00
AMA Dues Collection Payable	2,282.05
Annual Meeting Reserve	32,551.78
1966 History Reserve	4,207.67
Maternal Welfare Record Books Reserve (contra)	1,043.75
House Restoration and Replacement Reserve	2,660.61
Land, Buildings and Equipment Reserve (contra)	156,665.69
Due to Medical Student Loan Fund	14,980.00
Membership Directory Reserve	1,317.25
General Fund Surplus—April 30, 1966	200,906.31
Total Liabilities, Reserves and Surplus	$650,793.18

STATEMENT OF RECEIPTS AND DISBURSEMENTS
GENERAL FUND

May 1, 1965 to April 30, 1966

RECEIPTS

Cash Balance, May 1, 1965					$223,918.80
Assessments:	*State Dues*	*AMA Dues*	*Special*	*TOTAL*	
Atlantic	$ 6,120.02	$ 6,390.00	$ 775.00	$ 13,285.02	
Bergen	31,013.63	25,177.50	4,030.00	60,221.13	
Burlington	6,040.06	5,850.00	780.00	12,670.06	
Camden	15,486.72	16,605.00	1,970.00	34,061.72	
Cape May	1,553.35	1,395.00	205.00	3,153.35	
Cumberland	3,773.36	3,600.00	486.67	7,860.03	
Essex	60,767.02	57,037.50	7,771.67	125,576.19	
Gloucester	3,346.68	3,510.00	428.34	7,285.02	
Hudson	20,933.40	20,587.50	2,640.00	44,160.90	
Hunterdon	1,920.00	2,160.00	240.00	4,320.00	
Mercer	18,346.77	19,485.00	2,350.00	40,181.77	
Middlesex	14,026.77	14,692.50	1,801.67	30,520.94	
Monmouth	14,220.13	11,430.00	1,845.00	27,495.13	
Morris	12,333.39	13,095.00	1,565.00	26,993.39	
Ocean	4,893.38	4,747.50	635.00	10,275.88	
Passaic	22,673.42	18,202.50	2,885.00	43,760.92	
Salem	1,793.35	1,845.00	235.00	3,873.35	
Somerset	4,320.07	4,230.00	575.00	9,125.07	
Sussex	2,546.67	2,655.00	320.00	5,521.67	
Union	24,553.54	26,100.00	3,174.17	53,827.71	
Warren	1,586.68	1,620.00	205.00	3,411.68	
AMA Refunds		337.50		337.50	
Total Assessments	$272,248.41	$260,752.50	$34,917.52	$567,918.43	
Journal Advertising and other Journal Income				$ 47,284.53	
Annual Meeting Exhibits				27,126.79	
Membership Directory Income				1,651.00	
Interest Income				10,189.82	
Sale of Maternal Welfare Books				837.50	
Refunds of Budget Expenses				3,964.95	
AMA Dues Collection				2,693.70	
Investments Redeemed (at cost)				277,223.63	
Payroll Deductions from Employees—net				300.90	
Miscellaneous Receipts				515.22	
Total Receipts					$ 939,706.47
Total					$1,163,625.27

DISBURSEMENTS

Budget Accounts:	
A – 1 — Executive Salaries	$ 55,146.42
A – 2 — General Staff Salaries	58,895.30
A – 3 — General Executive Office Expenses	13,216.48
A – 4 — Executive Travel	1,693.17
A – 5 — House Maintenance	15,455.00
A – 6 — Treasurer	3,886.20
A – 7 — Finance and Budget Committee	22.40
A – 8 — Secretary	1,303.15
A – 9 — Salary Taxes	4,086.71
A – 10 — Insurance	4,668.20
A – 11 — House Reserve	5,120.47
C – 2 — Council on Legislation	3,554.67
C – 3 — Council on Public Health	1,648.32
C – 4 — Council on Public Relations	4,782.23
C – 5 — Council on Medical Services	173.10
D – 1 — President and Presidential Officers	7,991.94
D – 2 — AMA Delegates	5,120.21
D – 3 — Woman's Auxiliary	2,381.14
D – 4 — Committee on Medical Education	17.40
D – 5 — Conference Groups	14.80
D – 6 — Credentials, Membership and Directory	5,728.47
D – 7 — Disaster Medical Care	58.90
D – 9 — Archives and History	40.00
D – 11 — Medical Defense and Insurance	116.42
E – 1 — Board of Trustees	4,192.72
E – 2 — Contingent	6,391.66
E – 3 — Judicial Council	186.46
E – 4 — Legal	7,072.94
E – 6 — Medical Student Loan Fund	5,000.00

Total Budget Accounts	$ 217,964.88
Journal Publication and Expenses	65,931.07
Annual Meeting Expenses	23,879.40
AMA Dues Remitted	257,467.50
Purchases of U. S. Treasury Bills	315,225.53
Transfers to Medical Student Loan Fund	2,407.50
AMA Grant—Mental Health Congress	299.65
Assessments Refunded	1,233.10
AMA Dues Collection	2,580.31
1966 History Reserve	4,781.48
Bicentennial Fund	517.41
Library of Academy of Medicine	8,021.25
Total Disbursements	$ 900,309.08
Cash Balance, April 30, 1966	263,316.19
Total	$1,163,625.27

STATEMENT OF RECEIPTS AND DISBURSEMENTS
MEDICAL JOURNAL (Cash Basis)

May 1, 1965 to April 30, 1966

Budget Appropriation for Salaries and Taxes (contra) (1)		$ 11,022.28
Cash Receipts:		
Advertising—State Medical Journal Advertising Bureau	$29,881.54	
Advertising—Local	12,064.26	
Advertising—Classified	1,396.10	
State Medical Journal Advertising Bureau Rebate	1,820.65	
Subscriptions and Extra Copies	793.02	
Abstracts and Reprints	814.08	
Decrease in Accounts Receivable	514.88	
Total Receipts		47,284.53
Total		$ 58,306.81
Cash Disbursements:		
Publication Costs (2)	$48,369.12	
Journal Salaries (contra)	10,597.84	
Journal Office Expenses	162.61	
Journal Travel	291.64	
Discounts and Commissions—State Bureau	648.39	
Discounts and Commissions—Local	3,247.31	
Administrative Expenses—Local	1,283.50	
Insurance	328.56	
Salary Taxes (contra)	424.44	
Solicitation Expense	577.66	
Total Disbursements		$ 65,931.07
Excess of Disbursements over Receipts (2)		$ 7,624.26

(1) Disbursements include administrative salaries and taxes of $11,022.28 which were provided and paid from the General budget. These items have been shown as expenses of the *Journal* operation in accordance with action of the 1963 House of Delegates. No transfer of funds has been made from the General Fund to the *Journal* operation.

(2) Publication costs as shown include $6,593.98 of costs applicable to the period prior to May 1, 1965, and are included in order that the figures presented above will agree with the statement of cash disbursements of the General Fund.

MEDICAL STUDENT LOAN FUND

Balance Sheet—April 30, 1966

ASSETS

Cash:		
First Trenton National Bank		
Checking Account	$ 1,147.54	
Savings Account	24,026.74	
United Savings and Loan Association, Trenton	10,000.00	
Total Cash		$ 35,174.28
U. S. Treasury Notes (at cost) due 8/15/66, 4%		30,000.00
Notes Receivable—194 Loans to 119 medical students		170,652.95
Interfund Account—General Fund		14,980.00
Accrued Interest on Investments		250.00
Fund Balance April 30, 1966		$251,057.23

Note—The Fund balance includes $6,302.00 designated as the A. Barker Kump Memorial Grant and $5,030.00 as the Joseph E. Mott Memorial Grant.

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

May 1, 1965 to April 30, 1966

Cash Balance, May 1, 1965		$ 29,703.16
Receipts:		
Budget appropriation from General Fund	$ 5,000.00	
Contributions—General	4,219.00	
Contributions—Bicentennial commemorative	11,875.00	
Contributions—MSNJ Special Assessments	1,990.00	
Interfund transfer—General Fund	417.50	
Annual Meeting Excess of Reserve	3,133.80	
Collections of Notes Receivable	6,750.00	
Interest on investments and savings accounts	2,321.35	
Interest on Notes Receivable	256.87	
Proceeds from investments redeemed (at cost)	28,953.00	
Total Receipts		64,916.52
Total		$ 94,619.68
Disbursements:		
Purchase of U. S. Treasury Notes	$30,000.00	
Accrued interest and costs on investments	17.80	
Loans to Medical Students—30 loans	29,427.60	
Total Disbursements		59,445.40
Cash Balance April 30, 1966		$ 35,174.28

Approved (page 378)

Board of Trustees

Nicholas A. Bertha, M.D., Chairman, Wharton
(Reference Committee "A")



Full minutes of the meetings of the Board of Trustees have been distributed regularly to component societies, and summaries of its significant actions have been highlighted in THE JOURNAL. Therefore, as has been the custom, this report of the Board of Trustees will cover only such items as are not reflected elsewhere in the individual reports of committees and/or councils.

The Society's business continues to make heavy demands upon the time of the Trustees. Eleven meetings will have been held prior to this annual meeting, each one lasting a full day, or afternoon and evening. The Board members have served loyally and diligently. Average attendance at meetings has been 90%-100%. The councils and numerous committees have, by their work and comprehensive reports, greatly facilitated the orderly conduct of the Society's business.

Routinely, the Board has dealt with general matters brought to its attention — correspondence and resolutions from members, component societies, the American Medical Association, and outside organizations; appointment of representatives to local, state, and national meetings of concern to this Society; consideration of, and action on, the report and recommendations of the councils, standing, and special committees; cooperation with the departments of state government and with the allied professions.

Approved (page 375)

PROFESSIONAL LIABILITY PANEL
(Reference Committee "A")

In accordance with the action of the 1965 House, the Proposed Professional Liability Panel was "referred back to the Board of Trustees and appropriate committees for further study and submission in final completed form to the House of Delegates."

At its reorganization meeting, the Board referred the proposal to the Conference Committee with the Judiciary and the Bar for reconsideration, in line with the action of the House. The proposal was brought to the attention of the membership through the June 1965 issue of the *Membership News Letter,* and comments and suggestions were invited. The conference committee met several times; conferences were held with the Administrative Director of the Courts; and the Board carefully considered each report submitted. At its October meeting, on recommendation of the conference committee, the Board approved a revised version — which subsequently was approved by the Supreme Court — and directed that it be submitted to a special meeting of the House for action. This was in keeping with the hope of the Supreme Court that the Program become operative by January 1, 1966.

The House of Delegates, meeting on November 14, 1965, adopted the Professional Liability Panel Program, and on February 21, 1966, the New Jersey Supreme Court adopted "Rule 4:25B. P.L. Claims Against Members of Medical Professions; Procedure." The new Rule became effective immediately. The adoption of the Rule was the subject of a joint press release from MSNJ and the New Jersey Supreme Court.

Approved (page 375)

COMMITTEE STRUCTURE
(Reference Committee "A")

In accordance with the action of the 1965 House, the Board approved the continuance of the "Special Committee to Study the Spe-

cial Committee Structure of the Society, with the thought in mind of streamlining the number of committees when their function seems to have lost substance." This special committee was first appointed at the request of the 1964 House of Delegates. Study has continued on the general special committees and on the many special committees of the Board.

Approved (page 375)

Public Relations Personnel
(Reference Committee "A")

The Board referred to the Special Committee on House Maintenance, Staff Policies, and Personnel Relations, the recommendation adopted by the 1965 House concerning Resolution #1: "That the Board of Trustees give serious consideration to supplying additional staff members to the Executive Director, to help particularly with the problems encountered with regard to the workings of the Judicial Council, the Council on Legislation, and the Council on Public Relations."

On recommendation of the committee, the Board approved the engagement, effective April 11, 1966, of Mr. Thomas E. Leach, Jr., in the capacity of Executive Assistant to the Executive Director.

Approved (page 375)

Special Meeting of House of Delegates
(Reference Committee "A")

The Board of Trustees called a special meeting of the House of Delegates on Sunday, November 14, 1965, at 2:00 p.m., at the Notre Dame High School in Trenton. Of the 362 accredited members of the House (1965 list), 273 (75%) representatives attended the meeting. The meeting was called to discuss the Proposed Professional Liability Panel, which is separately reported above.

The special agenda for the meeting contained only one other item: a summary presentation of the current status and most recent developments of P.L. 89-97 — the Medicare Law — made by Ernest B. Howard, M.D., Assistant Executive Vice President of the American Medical Association.

Approved (page 375)

Conference of County Presidents
(Reference Committee "A")

At the request of component societies, the Board continued its sponsorship of conferences with presidents of component societies. Two conferences were held during the past year. The first conference was held on Sunday morning, November 14, 1965. A total of 22 presidents and/or presidents-elect represented 14 component societies. The second conference of county presidents was held on Sunday morning, March 20. A total of 17 presidents and/or presidents-elect represented 15 component societies. It was the unanimous opinion of those present at both conferences that these meetings continue to be successful and profitable and should be continued — at least twice a year, as has been the precedent.

In accordance with the suggestion made by the group last year, both presidents and presidents-elect of component societies were invited and urged to attend the meetings.

Among the items discussed by the group were the following:

1. *Purpose of Meeting* . . . The Board re-affirmed that the purpose of the informal meetings of presidents of component societies and the joint meeting with the Board is to give component society presidents and/or presidents-elect a forum for free and open discussion with one another and with members of the Board, to encourage improved mutual understanding of problems of MSNJ as well as those of component societies. It was thus agreed that as an informal discussion group, county officers have no authority to act as a unit — either for themselves or for their component societies.

2. *Congress of County Medical Societies* . . . In discussing this item with the Board, question arose as to the necessity and/or desirability of an organization of this kind. Many present were of the opinion that democratic processes for all members are freely and efficiently provided for on the basis of action at local level, from local to state level, and from state to national (AMA). Some expressed the opinion that, especially in these difficult times for organized medicine, fractional groups such as this may give the impression of disunity in organized medicine. Through elected delegates to the MSNJ House of Delegates, each component society,

through its delegates to MSNJ, has an official voice at state level. Through elected representatives to the AMA House of Delegates, The Medical Society of New Jersey has representation in the AMA. Thus, it cannot be alleged that each member of a component society does not have a voice in the operations of his local, state and national medical organizations, or that he cannot influence the actions and positions of organized medicine at all levels by means of existing due processes.

3. *Communicable Diseases* . . . Discussion centered about the confusion at local level concerning the mandatory reporting of communicable diseases. It was agreed that it would be immensely helpful if standardized forms for overall reporting of communicable diseases were evolved. County presidents were urged to discuss this matter locally and to forward any suggestions to MSNJ for consideration by the appropriate committee at state level. In this connection, each component society was sent a current version of the New Jersey State Sanitary Code, recently extensively revised. Component societies were likewise urged to encourage members to take more interest in the activities of local boards of health and, where possible, to seek appointment of physicians to those boards.

4. *Regional Planning* . . . component societies were urged to become better acquainted with the local regional planning councils being established throughout the state. These local councils are autonomous, and usually established by the formation first of a steering committee. It was emphasized that physicians, particularly, should become participating members.

5. *Instructed Delegates* . . . Question was asked whether or not a county delegate to the state annual meeting has the privilege of casting his own vote once he has been specifically instructed by the component society. Legal Counsel explained that this is not covered in the MSNJ Bylaws, but could be covered in the bylaws of individual component societies. It was his opinion that, once instructed by a component society, a delegate has the moral obligation to cast his vote as directed by the organization which he represents. If a member does not abide by his county's directive, he can always be replaced as a delegate the following year, or when his term expires.

Approved (page 375), with the following points stressed by the reference committee:

1. There is a great increase in the amount of information to be transmitted between individuals and organizations at county, state, and national levels.

2. Effective communications require that there be both sending and receiving of information.

3. Adequate channels for communication and action exist within the structure of organized medicine.

4. There are hazards in the presence of parallel lines of authority if those lines are not defined precisely.

5. There is need for greater participation by individuals and component societies in efforts to improve communications.

6. It is important that physicians take more active roles in regional planning committees and as members of boards of health.

7. The matter of unit voting by component society delegations is to be determined by the component society in its bylaws.

MSP Contract Inequities
(Reference Committee "C")

By action of the 1965 House, Resolution #4 (MSP and third party liability or multiple insurance) was referred to the attention of Medical-Surgical Plan. Medical-Surgical Plan reported that the Commissioner of Banking and Insurance had commented about the Plan's waiving the Participating Physician's Agreement in cases of third party liability or multiple insurance. (This agreement obligates the participating physician to accept Plan payments as payment in full for covered patients.) The Commissioner concluded that such waiver . . . "be oppressive and misleading to the subscribers, since even subscribers with very low incomes might have a small amount of insurance with another carrier which would affect the extent of coverage under the MSP contract." He further pointed out that inequities would develop in the treatment of persons who pay premiums for other insurance and persons who had no such other insurance. GHI of New Jersey had had a similar proposal rejected by the Department of Banking and Insurance. Therefore the Department declared that it could not approve the proposal of Medical-Surgical Plan. In consequence, to secure approval of the new Subscription Certificates, the Plan had to remove the provision to waive the Participating Physician's Agreement.

Approved (page 380), with the following opinion of the reference committee: It would be highly desirable that future efforts be made to improve this situation.

MSP Board of Trustees — Nominations
(Reference Committee "C")

The following nominations were approved by the Board of Trustees in December, to fill the vacancies in unexpired terms ending at the annual meeting in May 1968, which vacancies resulted from the resignation of Irving P. Borsher, M.D. (May 25, 1965), and the death of Charles W. Barkhorn, M.D. (October 8, 1965): Mr. Theron L. Marsh and Dr. Edwin H. Albano.

The following nominations were approved by the Board and are referred to the House of Delegates for action:

Three year term (1966-69)

Name	*Type of Practice*	*Member of Component Society*
Robert G. Boyd	Hospital Administrator	—
Joseph A. Cox, M.D.	Anesthesiology	Union County
Charles L. Cunniff, M.D.	Internal Medicine	Hudson County
Andrew P. Dedick, Jr., M.D.	Radiology	Monmouth County
Paul M. Forbes	(Businessman)	—
Warren Simons	(Businessman)	—
Sidney I. Simon, Ph.D.	(College Professor)	—
Robert E. Verdon, M.D.	General Practice	Bergen County

Also nominated for membership, to serve during their respective terms of office, are the Chairman of the Board of Trustees of the Hospital Service Plan of New Jersey, the President of the New Jersey Hospital Association, and the President of The Medical Society of New Jersey.

For the record, the following are the remaining members of the MSP Board of Trustees:

Terms expiring 1967	*Type of Practice*	*Member of Component Society*
Joseph P. Donnelly, M.D.	Obstetrics	Hudson County
Edgar P. Eaton, Jr.	(Businessman)	—
Joseph I. Echikson, M.D.	Internal Medicine	Essex County
Edwin T. Ferren, D.O.	General Practice	Camden County
Mortimer J. Fox, Jr.	(Businessman)	—
Jerome G. Kaufman, M.D.	Internal Medicine	Essex County
Joseph M. Keating, M.D.	Obstetrics	Passaic County
Elton W. Lance, M.D.	Surgery	Union County
Samuel J. Lloyd, M.D.	Surgery	Mercer County
Jesse McCall, M.D.	Internal Medicine	Sussex County

Terms expiring 1968	*Type of Practice*	*Member of Component Society*
Edwin H. Albano, M.D.	Pathology	Essex County
Lloyd M. Felmly	(Ret. Newspaper Ed.)	—
Theron L. Marsh	(Banker)	—
Rudolph C. Schretzmann, M.D.	Obstetrics	Bergen County
Charles O. Tyler, M.D.	Pediatrics	Camden County
Thomas J. White, M.D.	Internal Medicine	Hudson County

Approved (page 380)

Payment of Interns and Residents

(Reference Committee "C")

In compliance with an official directive, New Jersey delegates to the AMA introduced at the June 1965 meeting Resolution #6, calling upon the AMA House "to record itself as approving and supporting the principle that Blue Shield Medical-Surgical Insurance Benefits should be paid only to private physicians for eligible professional services personally rendered to their private patients." The resolution further called upon the AMA House "to report its actions to the National Association of Blue Shield Plans and to all constituent associations and component societies of the AMA for the purpose of encouraging a widespread adherence to this principle."

This resolution was extensively discussed before the reference committee. Supporters of the resolution, led by MSNJ's delegates, emphasized that the fundamental purpose for which Blue Shield and other voluntary medical-surgical plans were established by the medical profession was to enable the insured patients to obtain private care from private physicians of their choice. Stress was laid upon the fact that to assign such patients to interns and residents for their care, and to have an attending physician bill for the services rendered and turn the fees collected into a fund for the compensation of interns and residents was in violation of the fundamental intent of the insurance coverage. New Jersey's delegates led a fight from the floor to induce the House to reject the report of the reference committee (that Resolution #6 be not adopted and that the entire subject be referred to the Council on Medical Services for its further consideration and recommendation with the Council on Medical Education as appro-

priate). The AMA House of Delegates, by a standing vote, rejected the report and recommendation of the reference committee and adopted Resolution #6.

Approved (page 380)

MSP Non-Assignment Policy
(Reference Committee "C")

The Board of Trustees, after careful study of information supplied by Medical-Surgical Plan — and in view of previous actions of the House of Delegates' approving in principle payment directly to subscribers for professional services rendered by non-participating physicians — recorded itself as favoring the action of the Medical-Surgical Plan declaring as non-assignable payment to non-participating physicians. At the direction of the Board, in an effort to clarify any misunderstanding which may have arisen as the result of the action taken by MSP, component societies were advised in detail concerning the action taken by the Board with regard to inquiries made by certain members concerning this policy by Blue Shield. At the Board's request, a detailed statement of the Society's Legal Counsel on MSP benefits for non-participating physicians appeared in the December 1965 issue of The Journal (page 565).

Approved (page 380)

The AID Program
(Blue Cross-Blue Shield)
(Reference Committee "C")

The Board, through the Permanent Committee on Blue Cross-Blue Shield, has been in close contact with, and has followed with interest the developments resulting from, the operation of the AID program. On the basis of the still limited experience data thus far available, it is indicated that an overall reduction in hospital stays of approximately three-tenths of a day has been realized. The Board is of the opinion that the program has thus given indication of present and potential effectiveness, and recommends that it be continued for another year at least to afford it sufficient time to prove itself.

Recommendation

That the AID program be continued for another year at least to afford it sufficient time to prove itself.

Approved (page 380)

National (*AMA*) Programs
(Reference Committee "E")

On recommendation of the Council on Public Relations, the Board up-dated its 1964 resolution for introduction at the 1965 AMA meeting in June. The intent of this resolution (#36) was to insure continuance by the AMA of affording constituent associations the opportunity to discuss and formally to concur in advance concerning proposed national programs. The AMA reference committee was of the opinion that "sufficient flexibility of policy should be maintained so as not to tie the hands of the AMA Board of Trustees at critical times." It therefore recommended that the resolution be not adopted — and the AMA House approved the recommendation.

Approved (page 382)

Community Mental Health Centers
(Reference Committee "E")

Resolution #5 (from the Bergen County Medical Society), adopted by the 1965 House, called upon New Jersey Delegates to the American Medical Association to introduce and support a resolution urging the AMA likewise to encourage the enactment of H.R. 2985 and S. 513. These measures would provide for limited federal assistance to meet the costs of initial operation for community mental health centers.

The action was referred to the AMA Delegates, and an appropriate resolution (#41) was submitted to the AMA House at the June meeting. This resolution was strongly debated, and New Jersey was represented not only by its official delegates but by many physicians from New Jersey representing the point of view of New Jersey psychiatrists in support of

this measure as necessary in the public interest for adequate patient care. Favorable action of the House would have involved a modification of the AMA position concerning Federal assistance. In its report to the AMA House, the reference committee to which resolution #41 was referred declared: "While we agree with current association policy, we recognize that the need for Federal assistance for operating expenses by health and educational facilities is likely to appear and reappear in legislation. We believe, therefore, that the entire subject should be studied." The House adopted the recommendation of the reference committee that resolution #41 be referred to the AMA Board of Trustees "to review the subject of Federal assistance for operating expenses for health or medical educational facilities and to report its recommendations to the House." Such report has not yet been made.

Approved (page 382)

JEMPAC

(Reference Committee "E")

The Board takes this occasion to call attention to its approval in September 1962 of the establishment of a state "Pac" group in New Jersey and its authorization of solicitation by AMPAC of MSNJ members, as individual physicians, to join and support both JEMPAC and AMPAC.

At AMPAC's request, the Board designated official representatives to meet informally with representatives of AMPAC during the year. Following these discussions, the Board reaffirmed its policy that the Society maintain lines of disassociation from JEMPAC — emphasizing the desire and determination of the Society to maintain, as completely distinct and separate, the identities and activities of the two organizations.

Approved (page 382)

Medicare Law

(Reference Committee "F")

In consequence of the enactment of the Medicare Law (P.L. 89-97), the Board adopted the following organizational steps: (1) assigned to the Council on Medical Services overall responsibility to study and provide recommendations concerning all aspects of the Medicare Program as it will operate in New Jersey; (2) appointed as consultants to the Council on Medical Services in this area the President, President-Elect, Chairmen of the Councils on Legislation and on Public Health, Chairman of the Committee on the Chronically Ill and the Aging, Chairman of the Joint Council to Improve the Health Care of the Aged, and Dr. Frank J. Hughes (member of the New Jersey Board of Control); (3) transferred the Committee on the Chronically Ill and the Aging to the Council on Medical Services from the Council on Public Health; (4) supplied the services of the Legislative Analyst — as an extra duty contracted for — for the information and guidance of the Council on Medical Services in its deliberations.

Approved (page 383)

Health Care of the Aged

(Reference Committee "F")

The New Jersey delegation introduced Resolution #17 at the AMA Clinical Meeting in Philadelphia, calling upon the AMA to reconsider its decision to dissolve the National Council to Improve the Health Care of the Aged unless it was prepared to provide another AMA agency as an adequate substitute therefor. The Board of Trustees was of the opinion that the enactment of P.L. 89-97 (Medicare) and its pending effectuation would seem to intensify rather than diminish the necessity for the existence and operation of such a national agency under the auspices of organized medicine. In reporting to the AMA House, the reference committee pointed out that the American Hospital Association and the American Dental Association had already withdrawn from the joint council. It further reported that — while it agreed with the intent of Resolution #17 — existing programs could be assumed by departments within the AMA. It was the opinion of the reference committee, therefore, that the objectives of

the resolution had been accomplished. The AMA House approved the recommendation of the reference committee that Resolution #17 be not adopted.

Approved (page 383)

Hospital Based Specialists
(Reference Committee "F")

At the request of the Radiological Society of New Jersey, the Board re-affirmed a position which it has maintained over the years and which was the subject of a Resolution (#14) approved by the Society's 1965 House of Delegates:

Resolved, that The Medical Society of New Jersey reaffirms that the practice of Pathology, Radiology, Anesthesiology, and Physical Medicine are branches of the practice of medicine and that the services of Pathologists, Radiologists, Anesthesiologists, and Physiatrists are professional services and not hospital service, and therefore fees for the services of these physicians do not belong in any benefits paid for hospital services from any source. . . .

Approved (page 383)

Health Facilities Planning Council
(Reference Committee "F")

The Board authorized a contribution of $5,000 in 1966 to the HFPC, to be paid after June 1, 1966, with no commitment as to succeeding years. In considering this request, the Board noted its action of December 1965 that a one-time contribution of $5,000 be given to the Health Facilities Planning Council for New Jersey. However, the Board also took into consideration the action of the 1965 House in approving Resolution #23 — in which MSNJ affirmed its continued official support and membership in the Health Facilities Planning Council of New Jersey.

Approved (page 383)

Air Pollution Control
(Reference Committee "G")

A recommendation from the Council on Public Health which was approved by the 1965 House of Delegates called upon the Board of Trustees to make the Subcommittee on Air Pollution a special committee of the Council on Public Health. The Board implemented this recommendation, and the Committee on Air Pollution reports this year to the House as a special committee to the Council on Public Health.

Approved (page 385)

Mental Health Committee Structure
(Reference Committee "G")

As part of its annual report, the Special Committee on Mental Health has recommended to the 1966 House that it be elevated to the status of an administrative council with special committees, as necessary, to deal with alcoholism, drug addiction, mental retardation, mental illness of children and adolescents, epilepsy, neurological disorders, and psychiatric disorders of the aged. This item is reported in detail in the annual report of the Committee on Mental Health.

The Board of Trustees recorded itself as approving this recommendation and so reports to the House of Delegates.

Recommendation made under Committee on Mental Health (page 385)

Heart Disease, Cancer and Stroke
(Reference Committee "G")

By action of the 1965 House, MSNJ has recorded itself as supporting the laudable purpose of the President's Commission on Heart Disease, Cancer, and Stroke in its attempt to further increase medical knowledge and therapy of these crippling diseases. At the request of the New Jersey Commissioner of Health, the Board designated representatives to attend meetings at local level in connection with regional cooperative efforts authorized under the relevant federal legislation enacted. MSNJ was designated a representative agency in the New Jersey planning group and was requested to authorize an official to sign, in behalf of MSNJ, as incorporator of the "New Jersey Joint Committee for Implementation of P.L. 89-239." Dr. Joseph R. Jehl, President-Elect, signed as the incorporator for MSNJ and was designated as Trustee to represent

the Society during the first year of the incorporation.

Approved (page 385)

Bicentennial History

(Reference Committee "H")

Under the direction of the Society's Historian-Archivist, Dr. Fred B. Rogers of Trenton, a comprehensive one-volume history of MSNJ, "The Healing Art: The Medical Society of New Jersey Through Two Centuries 1766-1966", will be one of the features of the Bicentennial Celebration. A copy of the book — 420 pages, with 75 illustrations — will be mailed to each MSNJ member in good standing. Additional copies will be available for purchase.

Approved (page 387), including the following comments of the reference committee: The reasons for delay in publication were given at a meeting of the House of Delegates. The committee looks forward to its publication date, because of the very conscientious and capable author, Dr. Fred B. Rogers.

Supplemental Report

The following items have been acted upon by the Board of Trustees since the initial mailing of Annual Reports to members of the House. They are as follows:

AMA Proposed Membership Dues Increase

(Reference Committee "A")

The Board of Trustees has given very careful study to the proposal made by the American Medical Association for a $25.00 per annum per capita increase in membership dues. In an attempt to evaluate the fiscal facts that are offered as the basis for the proposal, the Board sent representatives to the AMA headquarters in Chicago to examine available financial records. The Board is keenly aware of the expressed opposition of eight of the component societies of The Medical Society of New Jersey to such increase. The Board itself is not disposed lightly to agree to such increase.

In consequence, the Board, meeting on the evening of Friday, May 13, caused to be prepared the following resolution, and presents it to the House for consideration and action:

WHEREAS, the American Medical Association has requested an increase of $25.00 per annum in membership dues, as necessary for the maintenance of its operation; and

WHEREAS, eight of the twenty-one component societies of The Medical Society of New Jersey have recorded opposition to that proposed increase; and

WHEREAS, it is greatly feared that such increase in dues will result in a marked decrease in AMA membership; and

WHEREAS, such relevant financial figures as are available indicate a progressive expansion of American Medical Association activities and a constant increase of expenditures — from $12 million in 1958 to $28 million in 1966; and

WHEREAS, in consequence, the American Medical Association contends that its operating reserve has been reduced to a dangerously low level; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey record itself as disapproving the proposed $25.00 increase in AMA membership dues, and that it recommend to the House of Delegates of the American Medical Association, that, in lieu of the proposed increase, it vote a special membership assessment of $10.00 per capita for one year, to be earmarked exclusively for the replenishment of the operating reserve; and be it further

RESOLVED, that no withdrawal from that operating reserve be permitted except by explicit action of the AMA House of Delegates; and be it further

RESOLVED, that the American Medical Association be called upon forthwith to re-examine all its activities for the purpose of reducing expenditures in all but essential and proper areas.

Approved (page 376)

Discrimination in Admission of Physicians To Units of Organized Medicine

(Reference Committee "A")

The Board of Trustees has studied the resolutions submitted from component societies concerning Discrimination in Admission of Physicians to Units of Organized Medicine. While unanimously supporting the principles and purpose of the resolutions, the Board noted that the final resolves of all the related resolutions call upon the American Medical Association to revoke the charters of constituent associations that offend by indulging the practice of discrimination alluded to. The American Medical Association does not charter constituent associations or component societies,

nor does it admit constituent associations as such to membership. All membership in the American Medical Association is on an individual, voluntary basis.

In order to accomplish the purpose for which the related resolutions have been introduced, the Board of Trustees, meeting on the evening of Friday, May 13, prepared the following resolution which it offers for consideration of the House and its reference committee with regard to the questions involved:

WHEREAS, The Medical Society of New Jersey has, since 1870, held as its undeviating policy that "Race, color, and creed are no barrier to membership, and that certified competence and character should be the only criteria for membership in any scientific body;" and

WHEREAS, it is alleged that membership in the American Medical Association is being denied by virtue of discriminatory practices at county and state levels; and

WHEREAS, there is no American Medical Association mechanism of appeal of which a rejected applicant at county and/or state level can avail himself; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey recommend to the House of Delegates of the American Medical Association that such changes in the Constitution and Bylaws of the American Medical Association as are necessary be effected to assign to the American Medical Association Judicial Council the right and responsibility to receive and act upon appeals filed by applicants who allege that they have been unfairly denied membership in county and/or state medical societies.

Approved (page 376). In consequence, Resolutions #1, #10, #13 not adopetd.

Academy of Medicine of New Jersey

(Reference Committee "B")

Request was received from the Academy of Medicine of New Jersey, by the following formal resolution, that MSNJ continue to contribute to the Academy and its library:

WHEREAS, one of the functions of The Medical Society of New Jersey is to promote continuing education for its members; and

WHEREAS, a well-stocked medical library is an indispensable instrument of such a program; and

WHEREAS, the library of the Academy of Medicine of New Jersey is the only large medical library in our state open to all physicians; and

WHEREAS, in recognition of this, The Medical Society of New Jersey has helped support the Academy library through grants made for 1964-1965 and 1965-1966, and

WHEREAS, these services cannot be maintained without the continued support of The Medical Society;

THEREFORE BE IT RESOLVED that The Medical Society of New Jersey contribute to the Academy of Medicine of New Jersey and its library, and that there be allocated a sum of $2.50 per year for each dues-paying member of The Medical Society of New Jersey.

The Board noted that last year the Academy had requested a like contribution to support its library, and that the 1965 House had adopted a $5.00 per capita assessment for 1966, 25% of which was allocated to the Academy's library (approximately $8,500). In accordance with its approval of the recommendation of the Committee on Finance and Budget, the Board directed that the resolution be referred to the House of Delegates (in its Supplemental Report), with the recommendation that a contribution to the Academy in 1967 be the same as that adopted by the House in 1966.

Recommendation

That a contribution to the Academy of Medicine of New Jersey in 1967 be the same as that adopted by the House for 1966 (25% of special $5.00 per capita assessment).

Recommendation made under Finance and Budget Committee report (page 378)

Animal (Medical) Research

(Reference Committee "E")

At the request of the New Jersey Public Health Association, the Board of Trustees endorsed a policy statement, in which recommendation is made that animals assigned to the pens and shelters in New Jersey for the purpose of humane destruction be hereafter made available for medical research, thus eliminating the profit-motive for those given to stealing pets and vending them.

Also in response to a request from the New Jersey Public Health Association, MSNJ designated an official representative to work with them and with the New Jersey medical schools, universities, and research institutions in group discussions to consider formation of a New Jersey Society for Medical Research.

Approved (page 382)

Judicial Council

E. Vernon Davis, M.D., Chairman, Mount Holly
(Reference Committee "A")



The files of the Judicial Council continue to reflect overall efficiency in the statewide operation of the judicial mechanism. The Council has continued its precedent of scheduling meetings on the fourth Sunday of each month. However, the volume of business requiring its attention has necessitated fewer meetings this year than hitherto. The Council is indebted to the judicial committees of the component societies for their efficiency of operation and for their conscientiousness in regularly reporting all cases accepted for adjudication at local level and the dispositions made of them.

The Council recognizes, of course, that some judicial committees can further improve their functioning. The Council is striving — and will continue to strive — to revise and devise procedures, as necessary, to deal with all complaints promptly and effectively.

From the official files, the Council presents the following resume of its operations and those of its county judicial committees for the period extending from April 1, 1965 through March 31, 1966:

By Judicial Committees

Complaints reported as disposed of 33

Alleging:
- Dissatisfaction concerning fees 9
- Unethical conduct 6
- Dissatisfaction with services rendered 17
- Solicitation of patients 1

By the Judicial Council

Meetings held 5
Official communications acted upon 11
Appeal hearings granted 2
Formal opinions rendered 2

Ethical acceptability of:

1. a proposed program for soliciting members for the reading of Papanicolaou smears

2. a physician's assigning to a layman or registered nurse certain procedures

The foregoing opinions are presented in full as an appendix to this report.

Regulations

In late fall, the Judicial Council issued to all county judicial committees a revised set of "Regulations for the Processing of Grievances and Complaints" modified to reflect amendments adopted by the 1965 House of Delegates affecting Chapter VII of the MSNJ's Bylaws. At that time the Council emphasized the importance for the efficiency of the judicial mechanism that all judicial committees adhere strictly to these "Regulations." County judicial committees are reminded that only by means of full understanding and full cooperation can the judicial mechanism be brought to the level of dependable, functional adequacy.

Conference with County Committees

The Council has planned a conference in the fall with chairmen of judicial committees, to discuss with them the importance of conscientious and efficient functioning and prompt cooperation — especially as the Society moves into closer relationship with insurance companies and government under the Medicare Program.

Legal Considerations

From time to time, the Judicial Council is confronted with requests for opinion concerning the ethical and legal acceptability of certain procedures. Because these requests are increasing, the Council takes occasion to re-

mind all members that the concern of the judicial mechanism is limited to considerations of charges of unethical or unprofessional conduct. It is never the function of the judicial mechanism to make conclusions concerning questions of lawful practice. These questions lie exclusively in the realm of the State Board of Medical Examiners of New Jersey.

Principles of Medical Ethics

In conjunction with an appeal hearing, a member offered as the basis of defense for an unethical procedure his ignorance of the Principles of Medical Ethics. The Judicial Council has repeatedly emphasized that ignorance on the part of a member of the ethical and professional standards of actions and conduct to which he must conform does not exculpate such member from blame if he violates these standards. A physician is as fully bound by the standards of medical ethics and of professional conduct as he is by the exactions of civil law. Whether or not a member is unaware, or indifferent to, this fact does not in any way serve as an excuse. For this reason, the Principles of Medical Ethics are included in the "Appendix of Reference Information" in the *Membership Directory* — a copy of which is made available to each member in good standing of MSNJ.

AMA Conference

By designation of the Board of Trustees, the chairman attended the AMA Conference on Medical Ethics and Professionalism, held in Chicago on March 5-6, 1966.

Opinions

(1) ETHICAL ACCEPTABILITY OF A PROPOSED PROGRAM FOR SOLICITING MEMBERS FOR THE READING OF PAPANICOLAOU SMEARS

The Council was unanimous in its opinion that: (1) in this instance, since the physician is announcing the availability of his services to other physicians, there is no solicitation of patients involved; and (2) the charges for the services described should be uniform.

(2) ETHICAL ACCEPTABILITY OF A PHYSICIAN'S ASSIGNING TO A LAYMAN OR REGISTERED NURSE CERTAIN PROCEDURES

The Council considered a request as follows: "Is it proper, ethical, acceptable, or legal for a doctor to assign to a layman or a registered nurse the examination of patients for Pediculosis Pubis in the absence of the doctor, and for the doctor to solicit, receive, and rely upon a positive or negative diagnosis of this infestation as made by the layman or registered nurse, and then to prescribe or not prescribe treatment without seeing the patient?"

It was the unanimous opinion of the Judicial Council that, if the nurse or assisting attendant reports the presence of this infestation to the doctor and the doctor then directs that a certain procedure be carried out, there is no violation of the Principles of Medical Ethics and/or the standards of professional conduct, as long as the physician is aware of, and retains responsibility for, the case.

The Council pointed out that it is not the function of the judicial mechanism to make conclusions concerning questions of legality. It concerns itself only with questions of ethics or professional conduct. Therefore, the requested statement concerning legality cannot be supplied.

Approved (page 377), with the following notation of the reference committee: It is incumbent upon each physician to be familiar with the Principles of Medical Ethics, since ignorance of the Principles will not release him from liability before the Judicial Council.

Executive Director

Richard I. Nevin, Trenton
(Reference Committee "A")



Once again the inexorable wheel of life has completed a full revolution and the time has come for us to answer the question, "What kind of a year has it been?" . . .

It has been a deeply significant year for all of us, first, because of our completion as a Society of two hundred years of life; and, second, because the government was finally successful in its long sustained drive to insinuate itself into at least a portion of the operation of the provision of health care.

The uniformly long and vigorous life and growth of our Society through successive generations of formidable difficulties and changes should serve as an encouraging stimulus to all of us to conclude that, if we persevere in dedicated service to our ideals and to our profession as did our forebears, the probabilities are that we will survive and overcome the vicissitudes of time and change in our lives as they did in theirs. What they could do, we can do, as long as we are as courageous, able, and faithful as they.

It has been and is the habit of Medicine to succeed and progress, as it has been the unhappy wont of governments, across the centuries, to succumb to their own internal weaknesses, through overreaching themselves and underestimating others. Medicine must be unwaveringly disciplined in adherence to its highest ideals and principles. Thus fortified, it can face the future with honor and strength, entrusting the outcome to the divinity that shapes the ends of nations as of men.

It was a busy year because the intense activities touched off by the passage of the Medicare Law (P.L. 89-97), and progressively accelerating, were superimposed upon the burdens of regular Society concerns, already enlarged by the demands of our bicentennial celebration.

It was a gratifying year because, through the unstinting loyalty and cooperation of all — officers, councils, committees, and staff — we have acquitted ourselves, consistently, of all that has been demanded of us in the service of the Society, and we have done so not only with functional but with financial efficiency so marked as to enable us to point with pride to a substantial favorable balance of unexpended budgetary funds.

For me personally it has been a taxing but exhilarating year, which definitely left no time for moping boredom. With President Bedrick — who was at all times and everywhere an energetic, able, affable, and captivatingly friendly leader and spokesman for The Medical Society of New Jersey — I shared the overall responsibilities and activities by attending 191 conferences and meetings, visiting 17 component societies, fulfilling 14 speaking assignments, and making 7 journeys out of state on official Society business.

When all are worthy, few can be separately cited. I cannot too strongly express my respect for, and gratitude to, all the presidential officers, the members of the Board, and the members of our staff. They have been inspiring in their conscientious and wholehearted service to our Society. It was a grief to be deprived by illness of the presence and splendid abilities of Mrs. Edith L. Madden, our Administrative Secretary and Convention Manager, who for the last few months has been unable to attend at the Executive Offices. As long as she was able, she gave to the last full measure of her strength to the work of the Society, which she has so long loved and so well served. We all hope that in God's wis-

dom she will triumph over her present debilities and return, restored, to resume her place in our midst.

After fifteen years of identification with The Medical Society of New Jersey and of close association with its officers and members, I am more and more impressed with the importance of membership to the average physician. The benefits of membership usually stressed generally include the protection afforded to the practitioner through the scientific and professional information supplied in the scientific meetings and the official Society publications—such as The Journal, the *Membership Newsletter,* and the *Membership Directory* — all publications that are available to him (or her) as a benefit of membership. Important, too, is the fact that the member's interests and the standards of the profession are safeguarded in all the numberless areas of concern that are involved — from the field of law and insurance coverage, to relations with government, other professions, agencies, organized groups, and the public. The Society and all its agents and agencies are dedicated to and assiduously active in affording the member at all times and under all circumstances the advice, protection, and service that will insure for him the best attainable, if not the ideal, climate in which to live and practice.

But these are all benefits that the Society confers upon, or delivers to, the member. The greatest benefit of membership, however, lies not in what the Society gives to the member but rather what membership in the Society enables the member to give to his profession, to society, and to mankind.

If he will, the able and zealous member can mould the thoughts and actions of his colleagues, and by dint of his compelling influence, can command their support and power for the effectuation of his ideals and the constructive improvement of his and their life and times. Membership in the Society swings wide to the enlightened and dedicated individual the portal to greatness. It invites him, who by himself is weak, to control and command the minds and hearts of his colleagues and his contemporaries so that the right as he sees it and the good as he knows it may prevail for the benefit of all. No one can be great, we are told, unless he finds something to serve more important and dearer than himself. The Medical Society of New Jersey offers that something. It is a distinguished Society because so many of its members have given, and continue to give, generously of their personal worth and greatness to it. In so doing they have fulfilled themselves and have served their fellowmen . . . What further need be sought for or declared?

* * *

From time to time we are asked for a summary of activities of The Medical Society of New Jersey. So that such a summary may be available for ready reference, I append, as an addendum to this report:

The Medical Society of New Jersey in Action

The official business of The Medical Society of New Jersey can be considered under five headings:

(1) business centering about membership services and benefits;

(2) business dealing with the official operations of the Society through its agents and agencies;

(3) business deriving from the administration of Society concerns with reference to organized medicine;

(4) business arising from the administration of matters with reference to associated and cooperating non-medical groups and associations; and

(5) business dealing with the relations of doctors, individually and collectively, with the general public.

Routine operations under these headings include such matters as the following:

Group 1. Business centering about membership services and benefits:

1. Maintenance of official headquarters as a base for official operations of The Medical Society of New Jersey, including arrangements for meetings of official groups of the Society or approved medical organizations.

2. Maintenance of official lists of members, revised and corrected from week to week for accuracy.

3. Correlation of our official lists with those of component medical societies, on the one hand, and the American Medical Association, on the other.

4. Biennial preparation and distribution of the *Membership Directory.*

5. Preparation and publication of *The Journal* of The Medical Society of New Jersey, *Transactions of the House of Delegates,* and of the *Membership News Letter.*

6. Planning, organizing, and supervising all details of the Annual Meeting.

7. Assisting in placement of physicians.

8. Administration of the Medical Student Loan Fund of The Medical Society of New Jersey.

9. Processing of inquiries and problems submitted by component societies, groups of doctors, or individual members.

10. Negotiating contracts, processing schedules, and fulfilling the obligations involved in the Veterans Administration and ODMC Programs.

11. Maintaining availability of adequate medical liability and health and accident insurance, and protecting members' rights under the coverages.

Group 2. Business dealing with the official operations of the Society through its proper agents and agencies.

All official concerns of: The House of Delegates and its committees; officers of the Society and the Board of Trustees; the Judicial Council; the official liaison committees; the standing committees; the administrative councils and their special committees; and the special committees to the Society, the House of Delegates, the Board of Trustees.

Group 3. Business deriving from the administration of Society concerns with reference to organized medicine:

1. *With component societies* — presenting and cooperating in the carrying out of all recommendations, projects, and programs originating with MSNJ; and informing and advising component medical societies with reference to their handling of local programs and problems.

2. *With specialty societies* — channeling through "official intermediaries" all matters originating with our Society for their official cooperation; processing all requests for our Society's official consideration and action emanating from the specialty societies, and cooperating, through conferences and meetings, in the solution of special problems.

3. *With the American Medical Association* — at all levels, taking care of matters of common concern in the fields of legislation, public relations, and all special services; achieving effective representation for The Medical Society of New Jersey in the House of Delegates of the AMA, and in approved conferences and meetings of the AMA and of other state medical societies.

4. *With the Woman's Auxiliary to The Medical Society of New Jersey* — rendering and receiving cooperation and assistance at state and at county level and maintaining integration of activities.

5. *With representatives of the health insurance industry* — particularly the Medical-Surgical Plan of New Jersey and the Hospital Service Plan of New Jersey.

Group 4. Business arising from the administration of matters with reference to associated and cooperating non-medical groups and associations, including lay health organizations:

1. *State Government* — all branches are involved, especially the executive, the legislative, and the judicial; the Departments of Health, Education, Labor, Institutions and Agencies, Law and Public Safety; the professional boards; and the Divisions of Welfare Services, Motor Vehicles, Temporary Disability Benefits, and Workmen's Compensation.

2. *Federal Agencies* — such as Department of Health, Education and Welfare, the Social Security Administration, and designated intermediaries under National Health Care Programs.

3. *Allied Professions* — nursing, dentistry, pharmacy, the bar, and the hospital association.

4. *Other Agencies* — all civic, community, and service groups, at state and local levels.

Group 5. Business dealing with the relations of doctors, individually and collectively, with the general public:

1. Responsibility for all official publicity, including the presentation of speakers with official approval; responsibility for the channeling of matters which involve the Society's public relations interests.

2. Responsibility for cooperating with the Judicial Council and the statewide judicial mechanism of The Medical Society of New Jersey in handling all complaints and grievances.

3. Preparation and distribution of fortnightly *Health Hints* to the newspapers of the State, and of *Junior Health Hints* to the schools enrolled for that service.

4. Preparation and distribution of official news releases, and dissemination of authoritative information to news agencies.

5. Preparation and publication of the *Periodic News Letter* to cooperating agencies, as required.

Approved (page 377), with the following suggestion of the reference committee: That all delegates read the addendum to the report, which is a summary of the activities of MSNJ, pointing up the broad scope and complexity of the Society's endeavors.

Standing Committees

Annual Meeting

Jerome G. Kaufman, M.D., Chairman, Maplewood
(Reference Committee "H")



A planning meeting for the 1966 annual meeting in celebration of the Society's bicentennial was held in June in New York City during the AMA meeting, to develop definite proposals, prior to the joint meeting with section officers.

For the bicentennial celebration meeting only, several changes in the daily schedule were agreed upon; namely, exhibits are to be open from noon on Sunday through Tuesday afternoon; a General Session on Medicare is scheduled for Sunday afternoon; Tuesday, May 17, 1966, is designated as "Bicentennial Day," with a special scientific program to be presented in the morning, to be followed by a special bicentennial luncheon, after which will be a Bicentennial General Assembly, "An Historical, Scientific, and Civic Appraisal of The Medical Society of New Jersey," featuring outstanding guest speakers.

The Atlantic City Convention Bureau will sponsor an elaborate reception immediately preceding the Bicentennial Dinner-Dance on Tuesday evening. In order to accommodate this gala celebration day, the schedule of meetings of the House of Delegates has been revised for this year only, and there will be two intervening days between the second and third sessions.

Four joint scientific sessions are scheduled for Monday morning, and four for Monday afternoon. One section (orthopedic surgery) will not meet in 1966. For 1966 only, the committee agreed to waive the requirement that the number of guest speakers shall not exceed the number of member speakers. It was also agreed that expense allowances for guest speakers should be increased in order that they can be invited to remain over for the Bicentennial Day as guests of the Society.

There will be 26 distinguished speakers participating in the eight joint scientific sessions on Monday. Four authoritative participants are scheduled for the Sunday program of the General Session on Medicare; and three well-known speakers will participate in the Tuesday Bicentennial General Assembly.

For this year only, in lieu of scientific and educational exhibits, the committee has scheduled 17 "History of Medicine" exhibits and one special informational exhibit on Medicare (to be presented by the Social Security Administration). A total of 67 companies will offer technical exhibits. For the first time, all exhibits will be housed in Haddon Hall's new Exhibit Hall, located directly off the Hotel Lobby.

The sessions of the House of Delegates, the Exhibitors' Reception-Buffet Dinner, and the Bicentennial Dinner-Dance will be held in the beautiful new Pennsylvania Room, adjacent to the Lounge floor.

The advance program was mailed in early February, in order that all members could make arrangements to attend the Bicentennial meeting. Each issue of *The Journal* since August 1965 has carried reminders that in 1966 the Society is celebrating the 200th anniversary of its founding. All members have been consistently urged to attend the Bicentennial Annual Meeting.

Because of the heavy convention schedule in Atlantic City each spring, it is advisable to set the annual meeting dates at least four years in

advance in order to assure desirable dates and hotel accommodations. Haddon Hall has already expanded its facilities, and it is now possible for the House of Delegates to meet in a room adequate for a schoolroom setup.

The House of Delegates has already approved the following annual meeting dates, which have been confirmed with Haddon Hall:

201st annual meeting — Saturday-Wednesday, May 13-17, 1967
202nd annual meeting — Saturday-Wednesday, May 18-22, 1968
203rd annual meeting — Saturday-Wednesday, May 17-21, 1969

Recommendation

That the 204th annual meeting be held at Haddon Hall, Atlantic City, Saturday-Wednesday, May 16-20, 1970.

Approved (page 387), including the following comments of the reference committee: Suggestion is made that the Annual Meeting Committee (1) try to get less conflicting scheduling for the 1970 convention by such means as having the time of the meeting advanced; and (2) investigate the apparent shortage of hotel staff to handle the heavy traffic of incoming and outgoing guests.

Scientific Program*

George J. Kohut, M.D., Chairman, Perth Amboy
(Reference Committee "H")



A joint meeting of the Committee on Annual Meeting, the Subcommittee on Scientific Program, and the Section Officers was held on September 26, 1965, in the Executive Offices.

1966 Section Program

The Board of Trustees requested, for this bicentennial meeting, that the MSNJ sections combine for presentation of eight sessions — four in the morning and four in the afternoon — to be held on Monday, May 16. With the combined programs agreed upon by the respective section officers, the following eight scientific sessions will be presented:

Allergy, Dermatology, Pediatrics
Gastroenterology, Proctology, Metabolism, Surgery
Clinical Pathology, Medicine, Rheumatism
Ophthalmology, Otolaryngology
Anesthesiology, Obstetrics and Gynecology
Cardiovascular Diseases, Chest Diseases, General Practice
Radiology, Urology
Psychiatry and Neurology

Because the officers of the Section on Orthopedic Surgery had declined their election to office, this section will not participate in the 1966 annual meeting.

Bicentennial Speakers

Of special interest will be a bicentennial scientific session on Tuesday morning, May 17. It will feature a "Symposium on GI Bleeding," and will have three outstanding speakers. The afternoon of Bicentennial Day will feature a general assembly on "The Medical Society of New Jersey: An Historical, Scientific, and Civic Appraisal." Three outstanding speakers have been engaged for this discussion. The committee is convinced that the scientific sessions and the Bicentennial Day program (one scientific, one general) will offer the members a program of appeal and interest.

Congratulations are due to the section officers on their choice of interesting topics and selection of outstanding guest speakers. All, except two, are from out of state.

All members are urged to attend these sessions during this historical bicentennial anniversary meeting.

Approved (page 388)

Scientific Exhibits*

Milton Ackerman, M.D., Chairman, Atlantic City
(Reference Committee "H")



The committee took the following actions during the year, 1965-66:

1. The committee prepared a plan for implementing the directive from the Board of Trustees that the Scientific Exhibit Section for the Bicentennial Meeting contain exhibits dealing with the history of medicine and those showing the evolution and progress of medicine. The committee decided to forego the usual general mailing of application blanks and, instead, to solicit, by letters and personal contacts, organizations and groups which would be expected to have material for an exhibit of this type. This type of solicitation was carried out, and the committee obtained a number of suitable exhibits of the type requested by the Board of Trustees.

Standing Committees

2. In accordance with the directive of the Board of Trustees, the committee did not schedule a Motion Picture Exhibit for the 1966 Meeting.

3. In accordance with the directive of the Board of Trustees, the committee did not make arrangements for awards for Scientific Exhibits at the 1966 Meeting.

Approved (page 388)

* Subcommittees of Annual Meeting Committee.

Credentials

Marcus H. Greifinger, M.D., Chairman, Newark
(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and supporting credentials as submitted through component societies.

The following statistical breakdown reflects the committee's activities during the period April 1, 1965 to April 1, 1966:

	Associate	*Advancement to Active*	*Active*	*Total*
Received	235	206	51	492
Reviewed and found:				
Satisfactory	212	200	49	461
Unsatisfactory	1*	0	0	1
Pending	22	6	2	30

The committee again expresses appreciation to the officers of component societies for their cooperation.

Approved (page 377)

* Did not hold degree in medicine acceptable to this Society obtained from medical school approved by this Society at the time of his graduation.

Finance and Budget

Thomas C. DeCecio, M.D., Chairman, Cliffside Park
(Reference Committee "B")



A review of the expenses of the first ten months of the current administrative year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

The Journal

In comparison to past years, the anticipated Journal deficit has decreased for the second consecutive year. This can be attributed to several factors: (1) the second year that the 65% increase in advertising rates has been in effect; (2) the completion of the first full year with a new printer who has been able to print the monthly publication more cheaply than past printers; and (3) because of an overall better publication, the volume of advertising supplied both by the State Medical Journal Advertising Bureau and the local agent has increased.

The deficit for publication of The Journal, editorial office expenses and travel, editor's insurance and salary taxes, assistant editor's salary taxes, and other journal expenses will be charged off to the unexpended balance in the budget accounts at the end of the fiscal year. This will result in a net surplus in the 1965-66 total budget.

Approved (page 378)

Special Per Capita Assessment

For 1966, the 1965 House of Delegates voted a special per capita assessment of five dollars ($5.00) — to serve as a contribution to the Medical Student Loan Fund (50%) for use as loans in 1965-66, to the Bicentennial Fund (25%), and to the Library of the Academy of Medicine of New Jersey (25%) — to apply equally to all dues-paying members, with no reduction for associate members as in the past, and to be levied in addition to, and not as part of, the budgetary assessment, with both being paid at the same time.

The 1965 House of Delegates disapproved Resolution #10 from the Academy of Medicine of New Jersey — that there be allotted a sum of $2.50 per year for each dues-paying member of MSNJ; and Reference Committee "B" suggested (and the House approved) that any surplus monies from the Bicentennial Fund be turned over to the Library of the Academy of Medicine, and that the Academy's request be reconsidered in 1966 when the Bicentennial Fund may no longer be required.

In reviewing this House action, your committee wishes to recommend postponement of compliance until after the Bicentennial year is over (December 31, 1966), when the bicentennial financial situation will be reviewable and any excess monies will be determined.

Approved (page 378)

For 1967, your committee recommends that the House of Delegates vote a special per capita assessment of five dollars ($5.00) — to serve as a contribution to the Medical Student Loan Fund (50%) for use as loans in 1966-67, to the Bicentennial Fund (25%), and to the Library of the Academy of Medicine of New Jersey (25%). Your committee further recommends that the special per capita assessment apply equally to all dues-paying members, and that it be levied in addition to, and not as part of, the budgetary assessment, with both being paid at the same time.

Approved (page 378)

1967 Assessment

The computation of cash surplus at the close of the current fiscal year is estimated at $223,777.59—49% above the $150,000.00 sum which has been indicated as the desired surplus amount at the beginning of each fiscal year.

ACCOUNT	CURRENT 1965–66 BUDGET	FOOT-NOTES	PROPOSED 1966–67 BUDGET
A – 1 — Executive Salaries	$ 58,501.73	(1)	$ 69,328.00
B – F — Journal Salaries	10,858.93	(1)	12,050.00
A – 2 — General Staff Salaries	62,616.92	(2)	68,124.00
A – 3 — General Executive Office Expense	14,000.00	(3)	14,200.00
A – 4 — Executive Travel	2,070.00	(4)	3,610.00
A – 5 — House Maintenance	16,000.00	(5)	13,470.00
A – 6 — Treasurer	4,170.00	(6)	4,190.00
A – 7 — Finance & Budget	75.00		75.00
A – 8 — Secretary	1,300.00	(7)	400.00
A – 9 — Salary Taxes	4,185.42	(8)	5,487.00
A – 10 — Insurance	4,850.00	(8)	5,725.00
A – 11 — House Reserve	5,600.00	(9)	7,600.00
C – 2 — Legislation	4,200.00		4,200.00
C – 3 — Public Health	2,200.00	(10)	2,400.00
C – 4 — Public Relations	6,800.00		6,800.00
C – 5 — Medical Services	700.00		700.00
D – 1 — President—Presidential officers	8,850.00	(4)	9,850.00
D – 2 — AMA Delegates	4,620.00	(4)	8,630.00
D – 3 — Woman's Auxiliary	3,050.00	(4) (11)	5,675.00
D – 4 — Medical Education	100.00		100.00
D – 5 — Conference Groups	500.00		500.00
D – 6 — Credentials, Membership Directory	8,500.00		8,500.00
D – 7 — Disaster Medical Care	325.00		325.00
D – 9 — Archives & History	100.00		100.00
D – 10 — Blood Bank Commission	250.00	(12)	
D – 11 — Medical Defense & Insurance	300.00		300.00
E – 1 — Board of Trustees	5,200.00		5,200.00
E – 2 — Contingent	10,000.00		10,000.00
E – 3 — Judicial Council	500.00		500.00
E – 4 — Legal	8,300.00		8,300.00
E – 6 — Medical Student Loan Fund	5,000.00		5,000.00
Total	$253,723.00		$281,339.00

In accordance with Chapter X of the Bylaws, the dues year is January 1 to December 31 and the fiscal year is June 1 to May 31. The administrative year, including the budget which controls expenditures, is based on the fiscal year. It therefore becomes necessary to apportion the per capita assessment to fiscal years on the basis of 5/12 for the current fiscal year now closing and 7/12 for the new fiscal year soon to commence.

The proposed budget for 1966-67 is $281,-339.00. 7/12 of the 1966 assessment applicable to this proposed budget is $148,914.04. This leaves $132,424.96 to be raised by 5/12 of the 1967 assessment. On the basis of 6,300 paid members as of May 31, an assessment of $50.45 per capita will be necessary in 1967 to raise this amount — 5/12 of $317,835.00 is $132,431.25. However, since the estimated cash surplus as of May 31 is $223,777.59 and the desired minimum cash surplus at the close of each fiscal year has been set at $150,000.00, the 1967 assessment can remain at $40.00 per capita by applying $27,431.25 from surplus toward the amount to be raised. $132,431.25 less $27,431.25 leaves a net amount of $105,-000.00 to be raised. 6,300 members paid at $40.00 is $252,000.00, 5/12 of which is $105,-000.00. The estimated net cash surplus at May 31 will then be $196,346.34.

1966-67 Budget

The proposed budget for 1966-67 totals $281,-339.00. It is the opinion of the committee that the budget should adequately provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted will necessarily be utilized.

As requested by the House of Delegates, the committee is listing explanatory footnotes on accounts showing a marked difference between current and proposed budgets.

Recommendations

1. That the budget for 1966-67 be adopted in the total sum of $281,339.00.

Approved (page 378)

2. That the 1967 assessment be adopted at $40.00 per capita, with no provision for a contribution to AMA-ERF.

Approved (page 378)

3. That the House of Delegates postpone the disbursement to the Library of the Academy of Medicine of New Jersey of any surplus monies from the Bicentennial Fund until such time as the bicentennial financial situation is reviewable to determine the amount of these surplus monies.

Approved (page 378)

4. That the House of Delegates vote a special per capita assessment of five dollars — ($5.00) to serve as a contribution to the Medical Student Loan Fund to be available for loans in 1966-67 (50%), to the Bicentennial Fund (25%), and to the Library of the Academy of Medicine of New Jersey (25%).

Approved (page 378)

5. That the special per capita level of contribution be set by the House in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time.

Approved (page 378)

FOOTNOTES FOR BUDGET

(1)—Increase due to salary increments to executive personnel and provision for additional staff member as executive assistant to the Executive Director (authorized by the Board of Trustees).
(2)—Increase due to merited increments granted for selected personnel in certain job classifications.
(3)—Increase due to additional office service expenses.
(4)—Increase due to AMA Annual Meeting in Chicago and AMA Clinical Meeting in Las Vegas and provision for expenses of executive assistant to Executive Director.
(5)—Decrease due to the elimination of MSNJ House car—not replaced as planned in 1965–66 Budget.
(6)—Increase due to allowance for purchase of a two-year supply of Treasurer's Forms.
(7)—Decrease due to the deletion of annual reports printing cost, to be charged directly to Annual Meeting Expense.
(8)—Increase due to higher salary tax rates and one additional employee to the permanent staff.
(9)—Increase due to additional capital equipment purchases anticipated in 1966–67 fiscal year.
(10)—Increase due to additional cost anticipated in conjunction with the 1966–67 program.
(11)—Increase due to additional cost anticipated in connection with MSNJ co-sponsorship with the Auxiliary of a reception honoring Mrs. Yaguda, the next President of the Woman's Auxiliary to the AMA.
(12)—Deletion due to Board authorization that any future payments be charged to Contingent (E-2).

Approved (page 378)

Honorary Membership

F. Clyde Bowers, M.D., Chairman, Mendham

(Reference Committee "H")



The committee conferred several times during 1965 in considering those proposed for honorary membership in MSNJ. Using the criteria established by our Constitution (Article IV, Section 7), the committee approved the following four names after thorough discussion of the merits of each individual. By unanimous agreement of the committee, we commend them to you for honorary membership in our revered Society in this, our Bicentennial Anniversary year.

Morris Fishbein, M.D.
Richard I. Nevin
Dickinson W. Richards, M.D.
Selman A. Waksman, Ph.D.

Approved (page 388)

Medical Defense and Insurance

Daniel F. Featherston, M.D., Chairman, Asbury Park
(Reference Committee "D")

During 1965-66, the committee met four times. The cooperation and interest of the committee were at a very high level, and the volume of work accomplished was extensive.

Professional Liability

The report of your committee at this time will not be as conclusive as we had hoped it would be. At the start of the program with our present Carrier, it was planned that at the end of a five-year experience period, MSNJ would establish its own rates for member-policyholders. The five-year period expired on November 1, 1965. As this report is written, the Carrier is in process of compiling the figures for submission to our Society. Unfortunately, they cannot be ready for submission to this House. Until we have the actual figures to study, it is impossible to make any dependable predictions as to future rates. While our experience hasn't been as good as we might wish, there is no indication of inevitable increase in premiums — such as apparently will, in the near future, be recommended by the National Association of Underwriters, whose figures after this year MSNJ will not use. It is significant to note at this time that several of the specialty groups who were accepted by another carrier have either had their policies cancelled or not renewed, or their coverage curtailed, with a substantial increase in rates.

The following chart of claims received for the five-year period (1961 to 1966) and the suits filed in the same period show a significant trend. While the number of claims and suits in the larger counties would be expected, the experience in the smaller counties (which have fewer members who have availed themselves of the coverage) indicates a very great hazard because one suit in a county with few participants can exhaust the premium power for that county for several years to follow. Another significant fact is that the claims experience in some smaller counties shows a claims loss comparable to that of the more populous counties. These counties undoubtedly will have to expect a reclassification of their status as far as premiums go. The counties involved are Middlesex, Monmouth, Ocean, and Somerset — where the claims and suits ratio has been particularly high.

County	Eligible Doctors as of 3/1/66	Insured as of 3/1/66	Claims Received in Year Expiring November 1							Suits Filed in Year Expiring November 1						
			1961	1962	1963	1964	1965	1966	Totals	1961	1962	1963	1964	1965	1966	Totals
Atlantic	166	37				2	3		5				1			1
Bergen	770	476	8	13	26	43	37	16	143		2	4	17	22	9	54
Burlington	150	35				1	2		3				1		1	2
Camden	393	36			3	1	1	1	6			1	1			2
Cape May	34	12														
Cumberland	102	44			1	3		3	7					1	2	3
Essex	1,573	968	12	46	78	82	71	24	313		11	32	50	40	11	144
Gloucester	71	11														
Hudson	596	325	1	15	12	8	20	5	61		1	6	6	11		24
Hunterdon	55	48			3				3			1		1		2
Mercer	456	170		4	8	7	5	4	28		1		3			4
Middlesex	374	277		17	27	34	21	17	116			13	27	17	11	68
Monmouth	353	236	1	8	16	22	14	10	71		3	5	13	13	5	39
Morris	316	230	2	13	15	31	10	3	74		2	1	9	9		21
Ocean	121	60		6	10	11	7	2	36			3	7	8	1	19
Passaic	598	359	3	19	38	23	30	14	127		6	15	14	12	2	49
Salem	42	4														
Somerset	115	99		8	11	6	10	2	37		2		1	13	1	17
Sussex	42	42			3	6	2	3	14			2	2	1	3	8
Union	640	404	7	22	23	53	70	10	185		2	7	21	51	12	93
Warren	38	21			1	2	1		4				2			2
Totals	7,005	3,894	34	171	275	335	304	114	1,233		30	90	175	199	58	552

The following chart of claims and suits filed in the five-year period (1961 to 1966) shows some striking trends. Of course, the physicians confining their work to medicine (or mostly medicine) are still the best risks, with obstetricians and gynecologists, orthopedic surgeons, and anesthetists being the worst risks on a percentage-wise basis. This circumstance may lead to special rate classifications for these specialists.

Specialty	Insured as of 3/1/66	Claims Received in Year Expiring November 1							Suits Filed in Year Expiring November 1						
		1961	1962	1963	1964	1965	1966	Totals	1961	1962	1963	1964	1965	1966	Totals
GP no surgery	303	1	6	12	3	4	2	28		3	3	3	1	3	13
GP minor surgery	553	4	17	14	32	33	7	107		4	7	17	16	6	50
GP major surgery	365	1	18	32	23	21	9	104		3	14	14	11	3	45
General Surgery	328	2	17	23	43	52	20	157		3	9	27	30	10	79
Internal Medicine	495	3	14	16	31	16	6	86		2	3	12	17	3	37
Cardiology	62	2		2	6	5	2	17			1	2	2	2	7
Gastro-Enterology	37	1	2	3		1		7			1		1		2
Allergy	33				2	4		6				1	1		2
Pediatrics	270	2	6	21	11	12	4	56		1	5	5	9	1	21
Obstetrics-Gynecology	254	3	23	28	44	32	9	139		5	7	21	23	6	62
Anesthesiology	195	9	21	33	26	32	13	134			9	14	18	3	44
Orthopedics	165	1	13	29	48	30	20	141		6	15	29	23	10	83
Radiology	110		3	9	9	16	4	41			2	3	11	1	17
Neuro-Surgery	27		4	2	4	3	2	15		2	2		3	3	10
Psychiatry	123		2	3	3	6	1	15				2	3	1	6
Neuro-Psychiatry	35			1	2	2		5				1	1		2
ENT no surgery	27		1					1							
Ophthalmology	129	1	1	4	5	2	3	16			1	5	3	1	10
Otolaryngology	66	1	3	7	13	8	3	35			3	5	5		13
Pathology	75			3	4	2		9			1	1	3		5
Dermatology	68	1	4	8	5	3		21			2	4	1		7
Proctology	30		2		1			3		1	1				2
Urology	58	1	3	8	9	8	4	33			3	6	6	2	17
Plastic Surgery	20		2	7	1	4	1	15			1	1	4		6
All Other	66				3	6		9				1	5	2	8
Totals	3,894	33	162	265	328	302	110	1,200		30	90	174	197	57	548

The following distribution of policyholders by counties shows two significant factors: (1) the total number of members insured has not significantly risen, and (2) the percentage distribution has remained the same. The lowest percentages of participation still lie predominantly in the smaller counties.

Year Expiring November 1	Insured	Claims	Suits
1961	2,794	34	
1962	3,642	171	30
1963	3,720	275	90
1964	3,859	335	175
1965	3,953	304	199
Total		1,119	494

Suits Filed 11/1/60 to 3/1/66	552
Suits disposed of to 3/1/66	232
Settled	81
Dismissed or withdrawn	100
Summary judgments (by motion)	8
Directed verdicts	16
Defendants' verdicts	26
Plaintiff's verdict with amount equal to, or less than, that offered in settlement	1

County	Doctors Eligible as of 3/1/66	Doctors Insured as of 3/1/66	%
Atlantic	166	37	22
Bergen	770	476	62
Burlington	150	35	24
Camden	393	36	9
Cape May	34	12	35
Cumberland	102	44	43
Essex	1,573	968	62
Gloucester	71	11	15
Hudson	596	325	55
Hunterdon	55	48	88
Mercer	456	170	37
Middlesex	374	277	74
Monmouth	353	236	67
Morris	316	230	73
Ocean	121	60	50
Passaic	598	359	60
Salem	42	4	10
Somerset	115	99	86
Sussex	42	42	100
Union	640	404	63
Warren	38	21	55
Total	7,005	3,894	56

Accident and Health Insurance

A total of 3,932 members have basic policies with the National Casualty Company — the majority with the extended coverage plan — and 3,004 members have policies in the Nationwide Mutual Insurance Company. Our accident and health insurance plans provide $1,200 monthly basic coverage and $1,200 monthly extended coverage. The basic plan provides benefits of five-years' accident and two-years' sickness, and the extended coverage plan extends the benefits to seven years for sickness for lifetime in the event of accident. The National Casualty Company paid $418,688.17 in disability claims to 471 members, and the Nationwide Mutual Insurance Company disbursed $188,792.16 in claims to 332 members.

Major Medical Expense Policy

The constantly increasing cost of hospital and major medical expenses has again affected our plan just as it has affected other medical insurance programs. As of March 1, 1966, we found it necessary to have our program modified to effect better control of mounting losses for nursing care and mental disease claims, while extending coverage for claims that went beyond our previous $10,000 maximum to a new $15,000 maximum. In making these necessary changes, in addition to giving effect to an increase in premium, our nurse coverage was extended to include licensed practical nurses in hospitals in addition to the previous coverage of registered nurses. Mental disease coverage, which previously had a $10,000 maximum, is now limited to $2,500, a figure in keeping with the general trends in this field of insurance.

Whereas in the previous years, $152,851.20 was paid in major medical claims to 150 claimants, this past year $180,660.70 was paid to 171 claimants. During the past year, the maximum policy limit of $10,000 was paid to two claimants.

A total of 2,980 members hold major medical policies, and 24 are held by survivors of deceased members under a special provision put into effect two years ago to take care of survivors.

High Limit Accident Insurance Policy

Our High Limit Accident Insurance Policy of the Nationwide Mutual Insurance Company — which provides up to $200,000 for accidental death benefit and total disability coverage for the member and up to $100,000 for the spouse (at a premium of $1.00 per $1,000 for the member and 60¢ per $1,000 for the spouse) — is getting an increasing response from our members. A total of 618 have purchased this insurance. This policy not only covers travel accidents, but all kinds of accidents around the home, at work, and the like. None of our policyholders has collected under this form of insurance.

Life Insurance

A total of 1,798 members are currently insured under this plan, with 2,112 Ten Thousand Dollar Five-Year-Renewable and Convertible Term Life Policies in force and 437 members holding converted units of insurance for a total of 2,568 Ten Thousand Dollar units of insurance, for a grand total in excess of $25,000,000 of coverage.

Since January 1, 1965, we have had 27 death claims: 22 have already been paid a total of $200,000 (four of these were claims for $5,000 each) and five claims are still pending. Of these death claims, ten were impaired risks when the policies were issued. Since inception of this life program in 1959, there have been 105 death claims. Of this number, 66 were impaired risks at policy issuance. These impaired risks were given policies in accordance with enrollment rules, and many of them would not have obtained insurance if it were not for the Medical Society enrollment. Since inception, $970,000 has been paid out thus far; and as previously indicated, five claims are still pending.

Appreciation

The committee especially wishes to thank Joseph Britton, New Jersey Manager for the

American Mutual Liability Insurance Company, and William Blanksteen of the E. & W. Blanksteen Agency for their continued cooperation with the committee and for the personal interest they have taken in the insurance need and coverage of members of MSNJ. We extend appreciation, also, to our Executive Director, Richard I. Nevin; and to Legal Counsel, Robert M. Backes; and to the members of our staff who have been so helpful during the past year.

The chairman wishes to thank each committee member: Doctors Fred A. Mettler, Ernest C. Hillman, Jr., Benjamin F. Slobodien, Elton W. Lance, and Jesse Schulman.

Recommendations

1. That the American Mutual Liability Insurance Company be continued as the officially designated carrier for our professional liability insurance program.

Approved (page 381)

2. That the E. & W. Blanksteen Agency be continued as the official broker for our accident and health, high-limit accident, major medical, and life insurance programs.

Approved (page 381)

Medical Education

Sherman Garrison, M.D., Chairman, Bridgeton
(Reference Committee "D")



The Committee on Medical Education has maintained an active interest in the study of continuing medical education in cooperation with the Academy of Medicine, the New Jersey College of Medicine, the New Jersey College of Dentistry, Rutgers Medical School, New Jersey Dental Society, and the State Department of Health.

The committee was also represented at the Governors Conference on Education, April 3.

The committee had no other assignments from the Board of Trustees for this year.

Approved (page 381), including recommendation of the reference committee: That the liaison of MSNJ with the various colleges and professional groups be stated explicitly in future committee reports.

Our Advertisers Merit Your Support

Not everyone can advertise in this JOURNAL. When you see an advertisement here, you know that the company or service has been stamped as "approved." As you read our advertising pages, you get a compact little course on what's new. And if you tell the company that you saw his notice in these pages, you remind him that this is a happy medium for his service or his company.

Medical Student Loan Fund

Luke A. Mulligan, M.D., Chairman, Leonia
(Reference Committee "B")



In its nine years of operation, the Medical Student Loan Fund has granted a total of $186,-702.95 in 194 loans to 119 New Jersey medical students. Fifteen loans have been repaid in full; seven loans are being repaid.

Requests for financial assistance by New Jersey medical students are continuing at such a rate as to necessitate additional monies. In 1964, and again in 1965, the House of Delegates adopted a $5.00 per capita assessment, 50% of which served as a contribution to the Medical Student Loan Fund, to be used for loans in the years of the assessment's adoption.

The Board of Trustees approved a recommendation of the Audit Review Committee that a committee be appointed to sit with the members of the MSLF committee; review rules, regulations, and general management of the Medical Student Loan Fund; and outline the discretionary powers of the committee. It was noted that all costs of operating the Fund are now paid by MSNJ out of its regular budgetary accounts — salaries, office expenses, telephone, postage, etc. It was proposed that the actual operating expenses be charged to the Fund. It was pointed out that administrative costs are a legitimate part of operating the Fund, that they now are considerable, and that they should be charged to the Fund even if only on a paper basis so that the cost of processing each loan would be known.

The Board approved the request of the committee that a time-cost study of Fund operations be made for the calendar year 1/1/66-12/31/66 for re-consideration, after that time, of charging operating costs on a paper basis to the Fund.

In 1957, the Board recommended that pharmaceutical houses not be approached for donations; that the project be widely publicized within the Society and donations from members encouraged; and that contributions from outside sources be accepted, but not solicited.

This year, the following recommendation of the Council on Public Relations was adopted: That pharmaceutical houses and others be invited to make commemorative contributions to the Medical Student Loan Fund in multiples of $100, in conjunction with the Society's bicentennial celebration; and that the names of donors of $500 or more be inscribed on a plaque to reside permanently in the Executive Offices. The plaque will read "Bicentennial Donors to the Medical Student Loan Fund of the Medical Society of New Jersey" followed by the list of donors. It was also suggested that donations of $500 from component societies and Woman's Auxiliaries be encouraged so that they, too, could be listed on the plaque.

The foregoing action will apply to the Bicentennial year (1966) only, after which the Board's 1957 action will again be in force.

The committee will sponsor an exhibit at the 1966 annual meeting. The exhibit will consist of charts showing sources of income; distribution of loans by county, medical school, and student year; and present location of graduate students (internship, residency, armed forces, private practice, etc.). A pamphlet describing the MSLF will be prepared for distribution. The honorary and memorial cards will be on display. Members of the Woman's Auxiliary will staff the booth.

DISTRIBUTION OF LOANS

County of Residence	*Medical School*	*Students*	*Loans Granted* 1957–1965	1965–1966
Atlantic	Hahnemann	2	$ 1,000.00	$ 1,000.00
	N. J. Medical	1	1,000.00	
	Pittsburgh	1	2,000.00	
	Temple	1		1,000.00
	Tufts	1	3,000.00	1,000.00
Bergen	Boston	1	1,000.00	
	Creighton	1		1,000.00
	Hahnemann	3	3,000.00	2,000.00
	N. J. Medical	7	9,000.00	1,000.00
	N. Y. Medical	1	1,000.00	
	St. Louis	1	1,500.00	27.60*
	Women's Medical	1	1,000.00	
Burlington	Duke	1	4,000.00	
	Hahnemann	1		1,000.00
	Jefferson	1	2,000.00	
Camden	Jefferson	2	2,000.00	
	Michigan	1	2,000.00	
	N. J. Medical	2	2,750.00*	
	Temple	3	3,500.00	
Cumberland	Jefferson	1	2,000.00	
Essex	Albany	1	2,000.00	
	Bern	1	2,325.35*	
	Duke	1	2,000.00	
	Hahnemann	2	2,000.00	2,000.00
	Howard	1	300.00	
	N. J. Medical	8	11,650.00	4,000.00
	N. Y. Medical	2	2,000.00	
	St. Louis	1	500.00	
	Temple	1	1,000.00	
Gloucester	Hahnemann	1	600.00	400.00
	Temple	1	2,000.00	
Hudson	Georgetown	1		1,000.00
	Harvard	1	1,000.00	
	Howard	1	400.00	
	N. J. Medical	16	19,500.00	2,000.00
	N. Y. Medical	1	1,000.00	
	Pittsburgh	1	1,000.00	1,000.00
	St. Louis	1	2,000.00	
Mercer	Hahnemann	2	3,000.00	
	Howard	1	1,000.00	
	Johns Hopkins	1	1,000.00	
	Meharry	1	250.00	
	Mississippi	1	3,000.00	
	N. J. Medical	3	7,000.00	1,000.00
	U. of Penna.	1	1,000.00	
	St. Louis	1	700.00	
Middlesex	Georgetown	1	1,500.00	
	Hahnemann	1	2,000.00	1,000.00
Monmouth	Columbia	1	2,000.00	
	Georgetown	1		1,000.00
	Jefferson	1	2,000.00	1,000.00
	Marquette	1		1,000.00
	N. J. Medical	2	4,000.00	1,000.00
	N. Y. Medical	1	2,000.00	1,000.00
	Temple	1	2,000.00	
	Up-State N. Y.	1	1,000.00	
Morris	Dartmouth	1	1,000.00	
	Duke	1	1,000.00	
	N. J. Medical	1	3,000.00	
Passaic	Jefferson	1	2,000.00	1,000.00
	N. Y. Medical	1	1,000.00	
Somerset	Georgetown	1		1,000.00
	N. Y. Medical	1	2,000.00	
	Temple	1	3,000.00	
	Western Reserve	1	1,000.00	
Union	Florida	1	1,000.00	
	Hahnemann	1	1,000.00	
	N. J. Medical	11	14,800.00	2,000.00
15 Counties	27 Medical Schools	119	$157,275.35	$29,427.60
				($186,702.95*)

(*Includes payment of insurance premiums.)

The committee endorsed the proposal that the Auxiliary sell an appropriate Bicentennial souvenir at the annual meeting for the benefit of the Medical Student Loan Fund.

The financial activities of the Fund during the year are included in the report of the Treasurer.

Present Location of Recipients of Loans

79 Graduates with M.D. Degree:

- 22 Interns
  - 8 in New Jersey
  - 14 Out-of-State
- 25 Residents
  - 6 in New Jersey
  - 19 Out-of-State
- 18 Army of the United States
- 2 United States Navy
- 1 U.S.P.H.S.
- 10 Private Practice
- 1 Not known — follow-up being made

40 Students Presently in Medical School:

- 15 Seniors
- 20 Juniors
- 5 Sophomores

119 Total

Contributions

The committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

General Fund

The Medical Society of New Jersey, Board of Trustees; County Medical Societies: Mercer and Union.

State Auxiliary Executive Board; Woman's Auxiliary to Newark Eye and Ear Infirmary; Past Presidents of Hudson County Auxiliary; County Auxiliaries: Atlantic, Bergen, Burlington, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Passaic, Salem, Somerset, Union, and Warren.

Dr. and Mrs. Samuel Bernson, Edith Stokes Bloomer, Dr. and Mrs. Morris Brescia, Dr. and Mrs. G. Raymond Brown, Dr. and Mrs. Robert Cornwell, Dr. and Mrs. Philip Fiscella, Dr. and Mrs. Floyd D. Gindhart, Dr. and Mrs. Harold Hughes, Dr. and Mrs. W. Robert Jacobs, Dr. and Mrs. John F. Kustrup, Dr. and Mrs. S. Lipschutz, Dr. and Mrs. Samuel J. Lloyd, Dr. and Mrs. Luke A. Mulligan, Dr. and Mrs. Paul H. Pettit, Dr. and Mrs. Paul E. Rauschenbach, Dr. and Mrs. Carl Records, Dr. and Mrs. George O. Rowohlt, Dr. and Mrs. Joseph Rube, Dr. and Mrs. Benjamin Schenker, Dr. and Mrs. J. R. Schwartz, Dr. and Mrs. John Scillieri, Dr. and Mrs. Paul H. Sparks, Dr. and Mrs. James H. Spillane, Dr. and Mrs. Lucius Tarchiani, Dr. and Mrs. Ciro S. Tarta, Mrs. Herman H. Tillis, Mrs. James Tsncalas, Mrs. H. Roy Van Ness, Dr. and Mrs. Frank Wolf, Jr., Dr. and Mrs. Keith R. Young.

In memory of

Mrs. Paul Aszody, Dr. Henry R. Balze, Dora Berenson, Maxine Bernstein, Mr. Edward Buckley, Mrs. Burdge, Mrs. F. Camerota, Mr. Louis Chmura, Mr. Benjamin H. Corson, Mr. Harry C. Cazzens, Jr., Mr. Emsley Crosby, Esther Dandors, Mrs. DeRosa, Mrs. Joseph H. Dwinelle, Mr. John L. Finger, Dr. Leonard Friedman, Mr. Carleton W. Gates, Mr. John Gould, Dr. William G. Herrman, Mr. Ralph Hoenie, Mrs. Lucy Hunter, Dr. William Ivins, Anna Kantor, Peraz La Barre, Mrs. Lally, Alice Mather Lippincott, Mr. Jack Lubin, Mrs. Grace Manville, Mr. Carl Alan Maxwell, Mrs. Rose Mazzotta, Mr. Edward McGough, Mrs. Catherine McGrath, Mr. George Merwarth, Mr. Micciele, Dr. Herschel S. Murphy, Mrs. Owen Murphy, Eva Nathan, Mrs. Agnes Patre, Mr. William Penza, Mrs. Ethel Place, Mrs. John A. Sakson, III, Grace Schubert, Mr. Walter Sheldrick, Mr. Shinefield, Mr. Eric Smith, Mrs. George N. J. Sommer, Sr., Mr. Charles Spun, Mr. Thomas Swick, Pauline Tillis, Dr. William H. Varney, Dr. Arthur Vaughn, Miss Jane L. Verdon, Maude Vogel.

In honor of

Mrs. Lewis C. Fritts, Mrs. Jesse T. Glazier, Mrs. Philip J. Kunderman, Mrs. Carl J. Records, Mrs. Edward Renquest, Dr. Robert Salasin, Dr. Arthur E. Sherman, Dr. Mildred L. Sylvester.

Bicentennial Commemorative Contributions

E. & W. Blanksteen Agency, Inc., Camden County Medical Society, Ciba Pharmaceutical Co., Geigy Pharmaceuticals, Gloucester County Medical Society, Johnson & Johnson, Knoll Pharmaceutical Co., Mercer County Auxiliary, Mercer County Medical Society, Organon, Inc., A. H. Robins Company, Inc., Roche Laboratories, Somerset County Medical Society, Wallace Laboratories, Warner-Chilcott Laboratories, White Laboratories.

Recommendations

1. That the House of Delegates appropriate monies to the Fund to be used for loans in 1966-67;

2. That the membership be urged to send contributions to the Fund; and

3. That the Woman's Auxiliary again be requested to make the Fund its number one project during the forthcoming year.

Approved (page 379), including the following suggestion of the reference committee: That measures be taken by the Medical Student Loan Fund Committee to see that recipients of loans will intern in New Jersey Hospitals.

Publication

George B. Sharbaugh, M.D., Chairman, Trenton
(Reference Committee "B")



This year, the committee concentrated its efforts on THE JOURNAL's part in the Society's bicentennial celebration. At the same time, we kept a conscientious eye on the economics of our operation.

BICENTENNIAL CELEBRATION

With the January 1966 issue, THE JOURNAL dressed itself for the bicentennial year. A new cover was designed to reflect the bicentennial seal of MSNJ and the seals of those county societies concurrently celebrating their sesquicentennial anniversaries: Essex, Cumberland, Middlesex, Monmouth, Morris, and Somerset.

Beginning with the August 1965 issue — to be continued through the July 1966 issue — THE JOURNAL has carried brief, varied reminders of the 200th anniversary year; a new department, called "Bicentennalia" was added. Dr. Fred B. Rogers, MSNJ's Archivist-Historian, ran monthly articles on outstanding men and events in the Society's history. Component societies were invited to submit compact, interesting historical items — which were published in the order in which they were received.

The gala celebration next month will also be the basis for a special anniversary commemorative issue in July 1966. Speeches of the civic dignitaries as well as scientific presentations will be featured. A special cover will be designed. Pictures from convention activities will be prominently displayed.

THE JOURNAL will still carry a "transactions" issue in August, reporting the actions of the House of Delegates.

JOURNAL CONTENT

A tabular comparison of material in THE JOURNAL for the last four years is here presented. Note that we increased our text material (scientific articles, editorials, news items, and so on) without pushing up the printing costs — no mean accomplishment in these days of sky-rocketing prices. The decline in advertising (from 781 to 482 pages in two years) afflicted all medical journals in the country. In our case, at least, it seems to have levelled off. Indeed, 1965 showed an actual increase over 1964; and in the first four months of 1966, this increase has continued.

	1962	1963	1964	1965
Book Reviews	28	21	34	39
County Society Reports	25	—	—	—
Editorials	36	28	24	25
Letters and Announcements	28	15	11	16
Original Articles	238	279	255	237
*State Activities	263	209	206	275
Total of text material	622	558	530	572
Advertising	781	620	482	485
Grand total of pages	1403	1178	1012	1057
Ratio: advertising/text	55.6%	53%	48%	46%

*Includes obituaries.

FINANCIAL PICTURE

The detailed financial statement covering THE JOURNAL is reflected in the annual report of the Treasurer. Results of financial changes initiated four years ago seem to have reached their stabilization point. Despite the lack of a spectacular increase in advertising for 1965, THE JOURNAL managed to continue reducing its operating deficit by several thousand dollars while increasing its content. The first four months of 1966 (not reflected in the tabular comparison) show an increase in pharmaceutical advertising.

EDITOR

The June 1966 issue will mark the 25th year

of Dr. Henry A. Davidson's service as Editor. Since its inception in September 1904, THE JOURNAL has had only five editors: one for as long a period as 25 years (Dr. Davidson) and one for so brief an interval as four months. Dr. Davidson not only holds the record of continuous service as Editor for our JOURNAL but probably has established seniority among all state medical journals in the country. So that this outstanding achievement may not go unrecognized, the Board of Trustees has directed that the June 1966 issue be dedicated to Dr. Davidson, to pay public tribute to him for outstanding services which reflect creditably upon his profession, his Society, and himself.

JOURNAL ADVERTISERS

No report would be complete without paying public tribute to our advertisers. The companies and places which advertise in our JOURNAL merit your support. The fact that their advertisements appear in THE JOURNAL is assurance of their reputability. By placing these notices, advertisers assist your JOURNAL and your Society. If you tell an advertiser that you saw his notice in THE JOURNAL, you remind him that this is a happy medium of service to his company.

Approved (page 379)

Woman's Auxiliary Advisory

George O. Rowohlt, M.D., Chairman, Dumont

(Reference Committee "H")



The official programs and projects for 1965-1966 were submitted and approved by the Board of Trustees.

The work of the Auxiliary was so efficiently planned and consummated that there was no need for a formal meeting of this committee.

The committee wishes especially to commend the Auxiliary on several of its activities:

1. Assisting in the formation of a chapter of the Woman's Auxiliary to the Student American Medical Association (WA-SAMA) in the Haddonfield-Cherry Hill area.

2. The efforts of one county, which resulted in national publicity for staging a most successful "Bicycle Safety Round-up" in its resort area.

3. The very successful and spectacular first health fair in the Woodbury area, which was attended by 3,000 people.

4. The 39th consecutive Health Education Day of one county, which was attended by 1,100 people who were guests of the auxiliary at luncheon. A past-president of the AMA was the principal speaker of the afternoon.

The committee also wishes to thank the Auxiliary for making the Medical Student Loan Fund its number one project for the year, and trusts hopefully that the sale of commemorative bicentennial plaques and plates for the benefit of the Medical Student Loan Fund will be substantially supported by the members of the Society at this convention.

The Auxiliary, at the request of the MSNJ Board of Trustees, is integrating its program this Bicentennial Year with the program of the Society to participate and aid in special portions of the program.

The committee wishes also to make special note of the fact that a former president of the Auxiliary, Mrs. Asher Yaguda, will assume the presidency of the Woman's Auxiliary to the American Medical Association in June.

It is with pleasure that the committee again expresses appreciation for the Auxiliary's continued support of MSNJ activities and its cooperative efforts to protect the health and welfare of the people of New Jersey.

Approved (page 388)

Revision of Constitution and Bylaws

Louis F. Albright, M.D., Chairman, Spring Lake
(Reference Committee on Constitution and Bylaws)



The following proposed amendment to the Bylaws, as submitted by the Union County Medical Society, was transmitted to the secretaries of component societies and to the Committee on Revision of Constitution and Bylaws under date of February 2, 1966 — in accordance with the provisions of Chapter XII of the Bylaws:

Bylaws

Chapter V — Procedure of Election

Current	*Proposed*
Section 1 — Nominating Committee	Section 1 — Nominating Committee
(a) Each component society shall elect at any meeting prior to March 31 of the fiscal year, one (1) of its elected to serve as a member of the Nominating Committee at the next annual meeting of this Society. At the same time, each component society shall elect one (1) of its elected delegates to serve as the alternate member of the Nominating Committee.	(a) Each component society shall elect at any meeting prior to March 31 of the fiscal year, one (1) of its elected delegates to serve as a member of the Nominating Committee at the next annual meeting of this Society. At the same time, each component society shall elect one (1) of its elected delegates to serve as the alternate member of the Nominating Committee. *The delegate shall cast one (1) vote for each five hundred (500) members of the component society, or fraction thereof; e.g., five hundred and one (501) members would entitle delegates to two (2) votes, etc. Each component society shall have at least one (1) vote.*

The committee reviewed the amendment, and — on advice of Legal Counsel — agreed that it properly belongs under Section 2 rather than under Section 1. The following version, with slight committee revisions, has been approved by Legal Counsel, and is submitted in this form for consideration and adoption by the House of Delegates:

Bylaws

Chapter V — Procedure of Election

Current	*Proposed*
Section 2 — Procedure of Nomination	Section 2 — Procedure of Nomination
(a) The chairman of the Nominating Committee shall be the Immediate Past-President of this Society, or, in the event he is unable or unwilling to serve, a member designated by the Fellows. The committee shall elect one (1) of its own members to serve as secretary, who shall call the roll of accredited members of the committee as certified by the Secretary of this Society.	(a) The chairman of the Nominating Committee shall be the Immediate Past-President of this Society, or, in the event he is unable or unwilling to serve, a member designated by the Fellows. The committee shall elect one (1) of its own members to serve as secretary, who shall call the roll of accredited members of the committee as certified by the Secretary of this Society.
The chairman shall read to the committee this section of the Bylaws (Chapter V, Section 2) before proceeding to any other business.	The chairman shall read to the committee this section of the Bylaws (Chapter V, Section 2) before proceeding to any other business.
(b) The Secretary of this Society shall furnish to the committee such information as is necessary for the proper conduct of its business, including a list of all offices to be filled.	(b) The Secretary of this Society shall furnish to the committee such information as is necessary for the proper conduct of its business, including a list of all offices to be filled.
(c) All nominations shall be made by individual alphabetical roll call of the counties, the first county to be called to be determined by lot. This order having been established at any annual meeting shall be the order for that meeting.	(c) All nominations shall be made by individual alphabetical roll call of the counties, the first county to be called to be determined by lot. This order having been established at any annual meeting shall be the order for that meeting.
The representative of each county, when his county is called, may nominate a candidate, second a nomination, or waive his privilege in favor of another county. The representative of the county so favored may then nominate a candidate, or second a nomination, after which the roll call shall be continued from the point where it was interrupted by the waiver.	The representative of each county, when his county is called, may nominate a candidate, second a nomination, or waive his privilege in favor of another county. The representative of the county so favored may then nominate a candidate, or second a nomination, after which the roll call shall be continued from the point where it was interrupted by the waiver.

	The representative of each county shall cast one (1) vote for each five hundred (500) members of the component society, or fraction thereof. Each component society shall have at least one (1) vote.
The chairman shall have only the right to vote in case of a tie.	The chairman shall have the right to vote only in case of a tie.

Recommendation of reference committee approved (page 389): That the subject be referred to the Board of Trustees for further study by a committee which would include members of the permanent Committee on the Revision of the Constitution and Bylaws. The reference committee realized the depth of the problem, but believed that the conclusions of the study can be completed and recommendations be made at the next meeting of the House of Delegates at the 1967 Annual Meeting.

Supplemental Report

The 1965 House of Delegates referred Resolution #19 to the standing committee on Revision of Constitution and Bylaws for study and report at the 1966 annual meeting. Resolution #19, introduced by a delegate from Bergen County, called for an appropriate amendment to the Constitution and Bylaws of The Medical Society of New Jersey to achieve "unequivocable (insurance) protection of *voting lay members* of the Judicial Committees of the county medical societies."

The Committee on Revision of Constitution and Bylaws regards the content of the resolution as involving basically an insurance matter, and noted the written assurance of the present carrier (American Mutual Liability Insurance Company) that the current coverage does apply to and protect *all* officially designated members of committees of component societies. Inasmuch as such protection is afforded under the prevailing coverage, the committee anticipates that like coverages, subsequently negotiated by MSNJ, will be equally embracing.

The committee further points out that the Constitution and Bylaws of MSNJ are intended to apply to The Medical Society of New Jersey as the parent, statewide agency; but that, within the bounds of general conformity, each component society is accorded a definite autonomy, which certainly embraces the prerogatives of establishing and constituting committees according to local conditions of need and desirability.

It is presently the policy of MSNJ to require that only MSNJ members hold regular memberships on its committees. There has been no official decision to change that policy. Therefore, there exists no reason to proceed to do so, especially inasmuch as (as has been indicated) component societies have latitude to act under such terms as are set forth in their own Constitutions and Bylaws. At the present time most component societies do not admit lay individuals to membership on their committees. It is the opinion of the Committee on Revision of Constitution and Bylaws that amendment to the Constitution and Bylaws of MSNJ so as to require them to do so would be violative of their right of autonomy in this regard.

In consequence, the Committee on Revision of Constitution and Bylaws is of the opinion that no compelling reason exists to amend the Constitution and Bylaws of MSNJ in the manner called for in Resolution #19, and it *recommends* that no such amendment be undertaken.

Approved (page 389)

Patronize Our Advertisers

The companies and places which advertise in this JOURNAL merit your support. The fact that their advertisements are here is assurance of their reputability. By placing these notices in these pages, they assist your JOURNAL and your Society.

Administrative Councils

Legislation

Jesse McCall, M.D., Chairman, Newton
(Reference Committee "E")



The legislative year begins with the second week of January and continues until the date agreed upon by both houses for their *sine die* adjournment the following year. Thus in one administrative year, the council concerns itself with activities that span two legislative calendar years.

1965 Legislative Summary

At noon on January 11, 1966, the 189th session (1965) of the New Jersey Legislature adjourned *sine die*. During that session, a total of approximately 1,353 pieces of legislation were introduced. The council gave study to 98 measures as relevant to the Society's interest and concern. Of those 98, (1) ten bills approved by MSNJ became law; (2) one bill actively supported by MSNJ became law; (3) one bill disapproved by MSNJ became law; and (4) six on which the Society had taken a position of no action were signed into law. A detailed summary report of all bills considered by the council during 1965 — including those signed into law — was reported in the January 1966 *Membership News Letter*.

1966 State Legislation

The 190th session (1966) of the State Legislature opened in the afternoon of January 11. Since that time the council has considered the bills listed below. It is obvious from this listing that the volume of bills considered by the council continues to increase each year. In all its deliberations, the council has had the benefit of the analyses and critical comments of the Legislative Analyst.

The Society's official position on all bills is regularly called to the attention of component societies, through the minutes of the meetings of the Board of Trustees; of legislators, cooperating agencies, county keymen, secretaries and executive secretaries, by means of official bulletins; and of the members, through the *Membership News Letter* and The Journal.

The Board of Trustees has adopted the positions indicated. All measures thus marked (*) are identical with bills of preceding years, and the official position of the Society concerning them remains the same. The regular range of official positions is as follows:

Active Support . . . all-out support for the measure;

Active Opposition . . . all-out opposition for the measure;

Approval . . . commended as satisfactory, but not actively supported;

Disapproval . . . rejected as unsatisfactory, but not actively opposed;

No action . . . considered, but not regarded as significant or relevant to the proper interests of the Society.

(Positions of active opposition and disapproval are always accompanied by a statement of reasons.)

*S-8 —To establish penalties, including loss of driving privileges, where a person's driving ability is impaired by consumption of alcohol. *Approved* with reference to the standards of percentile ratio of alcohol by weight to establish the presumption of impairment, but without commitment as to the fairness of the penalties declared.

S-9 —To provide that any operator of a motor vehicle shall have given consent to the taking of breath samples for the purpose of determining alcohol content in his blood and to establish presumptions in relation thereto. *Approved* with reference to the standards of percentile ratio of alcohol by weight to establish the presumption of impairment, but without commitment as to the fairness of the penalties declared.

*S-14 —To provide for a program of state aid to local health agencies. *Approved*

*S-21 —To exempt from taxation any equipment, facility, or device used primarily for the purpose of abating or preventing pollution of the atmosphere. *Approved*

S-25 —To require any motor vehicle to pass tests which demonstrate compliance with standards for control of air contaminants established by the Air Pollution Control Commission. *Approved*

S-26 —To authorize the Air Pollution Control Commission to formulate and promulgate codes, rules, and regulations establishing standards and requirements for control of air contaminants from motor vehicles. *Approved*

*S-29 —To broaden the protection afforded employers in second accident prior disability cases under the Workmen's Compensation Act. *Approved*

*S-38 —To revise the Workmen's Compensation Law
*A-1 —and to increase weekly and other compensation. *No Action*

*S-39 —To revise the Unemployment Compensation Law. *No Action*

S-41 —To require every district and regional board of education to appoint an advisory committee on narcotics to aid and advise the board of measures needed to prevent trafficking in, improper use of, and addiction to narcotics within the high school. *No Action*

S-42 —To increase state payments to county welfare
A-155—boards for aid to the blind to 75% in place of 50% of the balance of aid expenditures after deduction of allocated Federal funds. *No Action*

*S-51 —To increase the penalties of certain narcotics' violations and to forbid suspension of sentences. *Approved*

*S-52 —To provide a prison term of not less than 20 years for hiring or use of any child under 18 years of age in illegal sales or transactions of certain narcotic drugs. *Approved*

*S-53 —To forbid the suspension of any sentences for the illegal manufacture or sale of narcotic drugs. *Approved*

*S-73 —To prohibit the discharge of pollutant matter or materials into inland tidal waters and to regulate the operation of toilet facilities in vessels in said waters. *Approved*

S-93 —To provide immunity from liability to respond in damages as a result of acts rendered in good faith providing emergency first-aid and rescue services to paid police and fire department members. *Approved*

S-103—To include the State Department of Health as an enforcing agency for violations of established standards for use and construction of sewerage facilities. *Approved*

S-123—To permit boards of health to compel owners, lessors, etc. in charge of buildings used for stores, factories, or businesses to provide a 68 degree heating temperature between September 15 and May 15. *No Action*

*S-133—To prohibit use of force in taking samples to
*A-134—determine alcohol content of persons accused of driving a motor vehicle under the influence of intoxicating liquor. *Approved*

*S-142—To include under the scope of laws dealing with the practice of optometry any who offer and market for sale at retail to the general public spectacles or eyeglasses containing other than plano lenses. *No Action*

S-166—To revise generally the statutes governing food and drugs. *Approved*

S-177—To authorize the trustees of the New Jersey
A-330—College of Medicine and Dentistry to acquire for their use the Jersey City Medical Center. *No Action*

*S-179—To eliminate the need for a physician's certi-
*A-365—ficate in connection with an absentee ballot for temporary disability. *Disapproved,* because it would encourage self-diagnosis.

*S-183—To provide for education of students in the
*A-109—medicine and dentistry professions. *Approved*

*S-194—To regulate the practice or profession of removing superfluous hair from the body through registration and licensing of electrologists by the Board of Medical Examiners. *Approved*

S-210—To provide for the disposition of human remains and parts thereof by written instrument signed by the donor and two witnesses. *Approved*

A-21 —To provide for the special education of handicapped children. *No Action*

A-22 —To create the "Criminal Injuries Compensation Act of 1966" to provide compensation for innocent victims of crimes. *Approved*

*A-41 —To require "semi-private" room care for injured workmen under the Workmen's Compensation Law. *Disapproved,* because it is based on the unsound premise that the quality of medical and nursing care in hospitals is controlled by the expensiveness of the accommodations.

*A-42 —To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease, or tuberculosis shall be deemed to be an occupational disease. *Disapproved,* because it involves diagnosis by legislative enactment rather than by medical investigation.

*A-51 —To establish presumption in certain illnesses of firemen and policemen. *Disapproved,* because it involves diagnosis by legislative enactment rather than by medical investigation.

*A-54 —To give the Commissioner of Banking and Insurance authority over rates of payment made by medical service corporations. *Active Opposition,* because it would empower the Commissioner of Banking and Insurance to fix fees to be paid by MSP to participating physicians and would therefore constitute an unwarranted and unjustifiable denial of the fundamental right of the physician to set his own fee for professional services rendered, thus threatening the operation of the Plan, in disregard of the best interest of the approximately two million people of New Jersey who are its subscribers.

*A-116—To require crankcase ventilators on cars manufactured after June 30, 1967. *Disapproved,* because there is no provision for inspection or enforcement of the law by means of a supervisory or responsible body.

*A-126—To require the use of humane methods in the slaughter of livestock. *No Action*

*A-137—To permit the Air Pollution Control Commission to establish standards of quality of fuels and allowable emission of contaminants from motor vehicles and to establish standards for types of control devices or engine modifications for motor vehicles. *Approved*

*A-140—To reorganize and continue an eleven-member Air Pollution Control Commission in the State Department of Health. *No Action*

A-153—To increase state payments to county welfare boards for medical assistance to the aged to 75% in place of 60% of the balance of aid expenditures after deduction of allocated federal funds. *No Action*

A-161—To amend the regulations concerning physical connections in the transmission of public water supplies. *Approved*

*A-162—To provide that any person addicted to narcotics who hires or uses a minor under 18 years of age to distribute narcotics is guilty of a high misdemeanor. *No Action*

A-165—To prohibit sale or purchase of firearms in certain cases; to prescribe standards for registration, obtaining permits, and for hearings upon denial thereof. *Disapproved,* because it would be practically impossible to carry out the provisions of the law.

*A-170—To provide that assistance to the blind shall not be granted to those in need of prolonged care in an institution because of a physical or mental condition unless the institution is a medical one; is not one to which funds are permitted to be made by municipalities; and the person is not a tuberculosis or psychosis patient. *Approved*

A-173—To prohibit commitment of sex offenders to mental institutions other than those providing entirely separate facilities. *Approved*

*A-183—To regulate and license the collection and disposal of solid waste to create a Division of Refuse Control in the State Department of Health and an advisory council to said division. *Disapproved,* in support of the position of the Health Department that this legislation is unnecessary and undesirable.

A-197—To include the crimes of "incest" and "private lewdness" within the category of those offenses which require examination of the individual at the Diagnostic Center. *Approved*

A-216—To further define the phrase "glue containing a solvent having the property of releading toxic vapors or fumes." *No Action*

*A-223—To increase the examination and license fees in the Nursing Act. *Approved*

A-251—To cover podiatrists' services under workmen's compensation health accident, disability, sickness, or other insurance; or under any labor-management trustee or union welfare plans or any private insurance or welfare plan. *No Action*

A-255—To provide immunity from civil damage suits to volunteer first-aid or rescue squad workers who are not members of a volunteer fire company. *Approved*

A-280—To require establishment and maintenance for a system of fingerprint identification of patients in institutions treating mental diseases. *Approved*

*A-287—To require every motor vehicle manufactured after July 1, 1967 to be equipped with a signalling system. *Approved*

*A-300—To transfer certain approval powers over hospital service corporations from the Commissioner of Institutions and Agencies to the Commissioner of Banking and Insurance. *No Action*

A-312—To permit recovery of hospital, medical, and funeral expenses incurred for one wrongfully killed. *No Action*

A-313—To amend the Workmen's Compensation Act to allow a claimant in a death action to file a claim petition within one year after the death of the employee, notwithstanding that such period of one year extended beyond the period of the present limitation. *No Action*

A-316—To authorize a municipality to contract to provide health services to any non-profit private school. *Approved*

*A-317—To extend the time for filing petitions under the Workmen's Compensation Act in cases of exposure to ionizing radiation. *Approved*

*A-350—To require the county prosecutor to immediately initiate an investigation upon receipt of a complaint of physical abuse of children and to require report of the investigation to the Bureau of Children's Services. *Approved*

*A-397—To create "The Motor Vehicle Pollution Control Act (1966)" to control the emission of

pollutants from motor vehicles; to establish a Motor Vehicle Pollution Control Board in the Department of Health and to provide for administration. *Disapproved,* as unnecessary, because it is a duplication of facilities provided for in S-25.

Medical and X-Ray Technicians

The council continued its efforts to get an amendment to the Medical Practice Act to afford legal protection to medical and x-ray technicians (S-179 of 1965). Since its last report to the House, the council approached this problem from many angles.

The Legislative Analyst submitted a detailed report covering the statutes of all states regarding control of medical technologists through licensure or other means — with specific attention to New York, Pennsylvania, and Delaware. Only two states used the term "medical technologist" in their statutes defining and controlling the activities of such persons. He could find nothing that would assist MSNJ in this area. He concluded that the situation in this State is common throughout the country, but no one has gone as far as New Jersey in attempting to rectify the problem.

Last year, the Board approved an amended version of S-179 which had the approval — and embodied the suggestions — of the New Jersey Pharmaceutical Association. The council was assured that amendment of S-179 to include the Pharmaceutical Association's suggestions would satisfy any objection that body had to the legislation.

Following its September meeting, at which time all the elements involved in this legislation were thoroughly and protractedly discussed, the council made the following recommendations — subsequently approved by the Board:

1. That S-179 in its (then) present form be permitted to "die" in the 1965 session.

2. That early in the 1966 legislative session, the amended version of S-179 — which embodied the amendments submitted by the Pharmaceutical Association — be reintroduced, under bi-partisan sponsorship, if possible.

3. That, following such introduction, MSNJ mount an all-out, concentrated campaign towards the successful enactment of this legislation.

4. That the Board appoint a Task Force whose function it would be to decide upon and guide the procedures of a cooperative campaign — with MSNJ members, its Auxiliary, cooperating agencies, and paramedical personnel — to effectuate the passage of this legislation.

In February, a conference was held with the Commissioner of Health and Senator (Mrs.) Mildred Barry Hughes, to enlist Mrs. Hughes' support of MSNJ's desire to achieve amendment of the Medical Practice Act. In explaining the necessity and desirability of such legislation, in the interest of protecting the public welfare, the following points were stressed:

1. Such legislation has long had the support of the New Jersey State Department of Health, and the State Board of Medical Examiners of New Jersey.

2. Hundreds of employees in state institutions, government projects, and private physicians' offices — without whose services physicians could not take care of their patients — have been proceeding without legal protection.

3. MSNJ has recently submitted legislation which, in its opinion, would correct this situation. If the Administration cannot or will not accept the language of the bill, what would it suggest?

4. The increase in the doctor draft puts additional strain on physicians who are left to take care of the expanding population — thus requiring the services of additional technicians.

5. Implementation of the Medicare program (especially home care benefits) will require increased numbers of technicians to carry out the procedures for which coverage is available.

6. The future of medical care in the United States, as outlined in the Coggeshall Report, calls for expanded services by technicians.

The council pledged to take under consideration any suggestions that Mrs. Hughes could offer which would achieve enactment of this legislation.

As this report reaches its deadline, Mrs. Hughes has set up a conference with the Governor to discuss this entire matter. The results of the conference will be reported in a supplemental report to the House.

Privileged Communication

Upon recommendation of the Committee on

Mental Health, the Board referred to the council for study the question of whether or not it was feasible and/or desirable at this time for MSNJ to sponsor legislation to obtain privileged communication for all physicians in New Jersey. It was unanimously agreed that the resistance to such legislation by the judiciary and the bar continues; and in consequence, any effort to achieve enactment of such a statute would be futile. Expressions of various courts have indicated that the privacy of the patient may be invaded where the question of the public interest is concerned. As such, the courts would consider such a statute an overly protective measure not in the best interest of the public as a whole. The council agreed that, if there is to be a starting point for such legislation, it must come through the compilation of documented specific cases in which violated confidence has caused genuine harm. Upon receipt of sufficient documented instances, the council will proceed to attempt to bring about legislation which will establish privileged communication between physicians and patients in New Jersey.

Juveniles and Venereal Disease

At the Board's request, the council currently has under advisement with the State Department of Health the necessity and/or the desirability of sponsoring legislation to protect the physician treating juveniles for venereal disease. Attention of the membership has been called to the fact that, under present New Jersey law, any physician treating juveniles for venereal disease without the consent of the parents is liable to civil action.

The council has not been thoroughly convinced that amending legislation is desirable or necessary, since parents have the right to be informed concerning important matters affecting their children. However, the council has referred the matter to the New Jersey State Department of Health, to see if interest exists there in introducing legislation of this nature.

National Legislation

The council has followed several bills of national interest. Some of the more pertinent bills are those (1) to prohibit physicians from profiting from the sale of prescribed drugs; (2) to control supplies of dogs and cats for scientific study; (3) to establish regional centers to combat heart disease, cancer, and other major health problems; and (4) to control or regulate animal experimentation. In all matters of national legislation, the council is guided by the positions and recommendations of the American Medical Association.

* * *

The Council on Legislation is scheduled to meet at the end of April. The results of this meeting will be the basis for a supplemental report to the House, to bring the members up to date on current state legislation.

Approved (page 382)

Supplemental Report

Since preparation of the annual report of the Council on Legislation (distributed in advance to members of the House of Delegates), it has been necessary for the Council to hold another meeting in order to supply recommendations concerning State legislation recently introduced, and to report the most recent developments of the Society's proposed legislation to give legal protection to medical and x-ray technicians working under the specific direction of licensed physicians.

Current State Legislation

To bring the House up to date concerning legislation thus far dealt with and the Society's position as approved by the Board of Trustees, the Council respectfully presents this supplemental report. All bills thus marked (*) are identical with measures of last year — or preceding years — whose positions were the same.

S-142—To include under the scope of laws dealing (See S-335, S-336) with the practice of optometry any who offer and market for sale at retail to the general public spectacles or eyeglasses containing other than plano lenses. *Disapproved,* because it denies to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and discriminatory.

This bill, which was originally voted a position of "No Action," was reconsidered by the Board of Trustees, at the recommendation of the Council, and was given a final position of "Disapproval," as reported above.

S-233—To establish the procedure to admit and maintain non-tuberculosis patients, in a county tuberculosis hospital. *Approved*

*S-254—To forbid hypnotizing as a form of entertainment. *Approved*

S-270—To require every hospital to be equipped with an auxiliary power unit for use in periods of emergency; violation guilty as a disorderly person; effective September 1, 1966. *Approved*

S-290—To increase from $500 to $600 per year the A-489—amount of the state competitive scholarship to institutions of higher education. *Approved*

S-325—To create a "Practicing Psychology Licensing Act." *Active Opposition,* because it invades the Medical Practice Act and assigns to unqualified lay-individuals functions which they are not licensed or qualified to fulfill by permitting them to practice psychotherapy.

S-335—To include in the practice of optometry any (See S-142, S-336) person who prescribes or dispenses to the general public spectacles or eyeglasses containing other than plano lenses. *Disapproved,* because it denies to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and discriminatory.

S-336—To provide that any person who practices (See S-142, S-335) ophthalmic dispensing in violation of the act governing regulation of the practice shall be liable to a penalty of not more than $200. *Disapproved,* because it denies to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and discriminatory.

A-157—To permit dispensing of narcotic drugs with little or no addiction liability upon oral prescription order of a physician, dentist, or veterinarian. *Approved*

A-355—To define legal insanity as a defense to all crimes and to provide for commitment of the mentally ill. *Action Deferred,* pending further investigation and evaluation by other qualified medical and legal authorities.

*A-393—To create the New Jersey Hazardous Substances Labeling Act. *Approved*

A-425—To repeal the law granting immunity to non-profit charitable institutions from actions for damages for injury to persons. *Disapproved,* because the Society supported S-204 of 1958, which created the law A-425 seeks to repeal.

*A-475—To prohibit subrogation of hospital and medical service or any insurance company for any hospital or medical services. *Disapproved,* in support of the position of MSP.

A-507—To require fingerprinting and photographing of persons arrested for any offense relating to dangerous drugs. *Approved*

A-547—To supplement and amend various portions of the Uniform Narcotic Drug Law. *Approved*

A-548—To supplement and amend various portions of the statute concerning regulation and control of the handling, sale, and distribution of depressant and stimulant drugs. *Approved*

*A-556—To provide that any impairment of health of firemen or policemen caused by hypertension, heart disease or tuberculosis shall be presumed to have been received in the performance of duty. *Disapproved,* because it involves diagnosis by legislative enactment rather than by medical investigation.

A-592—To provide that no accident or health insurance policy shall terminate coverage of a dependent at age 19 where the dependent is incapable of self-support which is provided by the policy holder and where incapacity is by reason of mental retardation or physical handicap attained before age 19 and where notice is submitted. *No Action*

A-593—To provide that no hospital service corporation shall terminate coverage of a dependent at age 19 where the dependent is incapable of self-support which is provided by the policy holder and where incapacity is by reason of mental retardation or physical handicap attained prior to age 19 and where notice is submitted; to permit exclusion of such persons from coverage. *No Action*

A-594—To provide that no medical service corporation shall terminate coverage of a dependent at age 19 where the dependent is incapable of self-support which is provided by the policy holder and where incapacity is by reason of mental retardation or physical handicap attained prior to age 19 and where notice is submitted; to permit exclusion of such persons from coverage. *No Action*

A-617—To prohibit persons from placing, turning, or draining or placing where it can run, flow, wash or be emptied into any of the fresh tidal waters within the state any deleterious or poisonous substances of any kind. *Approved*

A-620—To prohibit persons from placing, turning, or draining or placing where it can run, flow, wash or be emptied into the Delaware River above or below Trenton falls any explosive deleterious or poisonous substances. *Approved*

A-670—To require every board of education to employ an optometrist. *Disapproved, with active opposition if bill moves,* because the school physician already has the obligation to screen for physical defects — including impairment of vision. The addition of an optometrist would, in consequence, be an unjustifiable and expensive redundancy.

A-671—To require the state and its subdivisions to accept reports and testimony of any licensed optometrist; to prohibit discrimination between licensed ocular practitioners and to prohibit interference with any individual's free choice of ocular practitioners. *No Action*

Medical and X-Ray Technicians

Through Senator Mildred Barry Hughes (Union County) a conference was arranged with the Governor, the Commissioner of Health, the President of the State Board of Medical Examiners, and representatives of MSNJ. The purpose of the conference was to impress upon the Governor the necessity of amending the Medical Practice Act to give legal protection to medical and x-ray technicians working under the specific direction of licensed physicians. The Governor was sympathetic to the Society's purposes and agreed that the need for legislative action in this area is pressing. He assured the Society that, if satisfactory legislation can be evolved, he will have it introduced in this session as an administrative measure. Agreement still remains to be reached with the Governor's legal counsel on the definition and scope of activities of medical technicians. A new draft was presented to the Governor, which has proved to be the most satisfactory version thus far submitted. With the approval of the Board, this most recent draft will be the basis for a final version acceptable to the Administration.

The New Jersey Commission on Radiation Protection has been working closely with MSNJ and the New Jersey Radiological Society in evolving legislation to certify x-ray technicians. It is expected that this legislation will be introduced this year and thus take care of the x-ray technicians previously included in the Society's proposed legislation.

Statewide Medical Examiners' System

The Society has not yet heard from the office of the Attorney General regarding a promised conference to discuss the Society's recommendation to the Governor for the establishment of a statewide medical examiners' system. It was reported that the Administration is presently so involved with financial and taxation problems (as well as the convention on reapportionment) as to have little time for other concerns which seem to be of less pressing character. In addition, the Society is engrossingly engaged with the forthcoming bicentennial meeting. As soon as the annual meeting is over, MSNJ will press for the promised conference.

Laboratory Animals

The Council has solicited and noted for reference the position of the American Medical Association on national legislation dealing with laboratory animals. The Council has been informed that of the approximately 45 related bills presently pending, it is expected one (H.R. 13881) will be reported out of committee for action the end of April. This measure would require the licensing of research laboratories and dealers involved in the procurement and utilization of dogs and cats for experimental purposes. It would further authorize the Secretary of Agriculture to set standards for licenses. The AMA has testified in opposition to this and similar legislation, on the grounds that it is unnecessary to extend restrictive control over research laboratories. It has, likewise, opposed those measures which would include other animals in addition to cats and dogs. The AMA believes it would be sufficient to require the licensing of dealers and to render unlawful the purchase of dogs and cats in interstate commerce. The effect would thus be to protect against the theft of these animals for experimental purposes.

In this regard, S. 3138 (and its companion H.R. 13426) have been introduced which would limit coverage to dealers in dogs and cats. S. 3138 makes provision for owners which H.R. 13426 does not. S. 3138 has received support from the National Society for Medical Research and the Humane Society. The AMA has taken no affirmative position on either measure, but has indicated that H.R. 13426 is within its policies.

Approved (page 382)

Medical Services

Nicholas E. Marchione, M.D., Chairman, Vineland
(Reference Committee "F")



The function and scope of activities of the council were substantially increased this year by action of the Board of Trustees which (1) transferred the Committee on the Chronically Ill and the Aging from the Council on Public Health to the Council on Medical Services; and (2) assigned to the Council on Medical Services overall responsibility to study and provide recommendations concerning (a) all aspects of the Medicare Program as it will operate in New Jersey; and (b) the maintenance of quality medical care. The council now has two special committees under its jurisdiction, whose activities are reported in detail in their individual annual reports.

Medicare Law

The council has been given full responsibility for overall consideration and guidance of Medicare activities in New Jersey. To assist the council in this area, the Board of Trustees has appointed as consultants the following: President, President-Elect, Chairmen of the Councils on Legislation and on Public Health, Chairman of the Committee on the Chronically Ill and the Aging, Chairman of the Joint Council to Improve the Health Care of the Aged, and Dr. Frank J. Hughes (a member of the New Jersey State Board of Control).

The council has formed subcommittees to deal with specific areas of Medicare concern, as follows: (a) Subcommittee on Utilization Review Procedures, in hospital and out; and (b) Subcommittee on Compensation of Physicians. To further assist the council in its dealings with official departments of state in implementing the Medicare Law, official liaison representatives from MSNJ were named to the Department of Health and to the Department of Institutions and Agencies.

As its first item of concern, attention was given (in November 1965) to the Governor's request for the Society's views on the new Medicare legislation. In making reply to the Governor, MSNJ reported that it had:

1. requested Medical-Surgical Plan of New Jersey to solicit designation as the official carrier for Part B of Title XVIII of Public Law 89-97;

2. urged the assignment to the Department of Institutions and Agencies of the responsibility of fulfilling the functions stipulated under Title XVIII and Title XIX of the Medicare Law;

3. declared its willingness to name a high-level advisory committee to help evolve satisfactory regulations and procedures for the effective implementation of the Medicare Law in New Jersey;

4. urged prompt action to plan and prepare for the operation of the program — particularly with reference to Title XIX, under which federal monies will become available to the states as of January 1, 1966.

Subsequently, the Secretary of Health, Education, and Welfare named the Prudential Insurance Company of America as the official carrier for Part B of Title XVIII. The Governor designated the State Departments of Health and of Institutions and Agencies to administer the operation of the Medicare Law in New Jersey. The Department of Health will implement Title XVIII of the Social Security Act and the Department of Institutions and Agencies will implement Title XIX of that Act. These two agencies will be linked by an intradepartmental committee which will provide integrated statewide management of this program of far-reaching importance to all in New Jersey. Substantial federal funds will be available for staffing and administering these new programs.

In designating the Department of Health to administer Title XVIII of the Medicare Law, the Governor pointed out that more than 50 health departments (both state and territorial) had been appointed to administer Title XVIII. It was his contention that the Department of Health has traditionally planned for community health services and that it provides leadership and technical assistance to

communities on a broad basis — specifically in the area of nursing, nutrition, physical therapy, social work, and health education.

Title XVIII is an amendment to the Social Security Act which provides for persons over 65 a basic hospital and related health care plan (Part A) and a voluntary supplemental insurance plan (Part B) covering medical and other related costs. This title therefore provides hospital care, nursing home care, outpatient hospital diagnostic services, home health services, and — with the addition of the supplementary plan — helps to pay the cost of a variety of health services including services of physicians and surgeons.

Title XIX is an amendment to the Social Security Act which combines all the medical provisions for the needy covered in five titles of the existing Act. It expands the medical assistance for the aged program to needy persons under the programs for dependent children, the blind, and the permanently disabled.

The council's attention also centered about the provisions of I-C of the law (Title XVIII) requiring a "utilization review plan," which is intended to review utilization — on sampling or other basis — and to safeguard overutilization. The primary aim is to keep this appraisal from becoming a function of government, and the council was unanimous in its agreement that it is imperative that each such utilization review committee be headed by a physician. To achieve this, the council alerted component societies to the desirability of appointing utilization review committees to implement Public Law 89-97. In addition, hospital staffs, through their chiefs, were alerted to the desirability of forming utilization review committees in every hospital in New Jersey and were urged to become familiar with the educational and functional uses of these committees as outlined in the Medicare Law.

The council cannot emphasize too strongly the necessity of utilization review committees' being established at local level without delay. The law provides that these committees may be established by the Commissioner of Health, if local medical societies do not organize them. The Commissioner has declared his desire that these utilization committees be headed by physicians. It is imperative that county society review committees be established and be functioning without delay. The council is eager to cooperate with county review committees in every possible way and will supply for them from time to time such information and advisory material as it thinks would be helpful to them, when it is available.

Specialty Groups

At the request of the specialties involved, the council met with representatives of radiology, pathology, anesthesiology, and psychiatry to help them evolve their position and to develop recommendations in preparation for the inauguration of the Medical Program. From the discussion evolved the following conclusions:

1. MSNJ supports — and has for a number of years — the position that the practice of pathology, radiology, anesthesiology, and physical medicine are branches of the practice of medicine, and the services of such specialties are professional and not hospital services.

2. MSNJ supports the position that since the professional services rendered by physicians in hospital-based specialties are not hospital services, the fees for such professional services do not belong in any benefits paid for hospital services from any source.

3. MSNJ supports that section of the Medicare Law which provides that fees for services rendered by hospital-based specialties shall be compensated under Part B of Title XVIII.

4. MSNJ supports the hospital-based specialties in their determination to conduct their practice in such a manner and under such arrangements as will enable them to bill and receive compensation directly for professional services rendered.

5. MSNJ supports the recent policy declarations of state and national hospital-based specialties, but recognizes that individual members are still at liberty to make whatever arrangements they wish with hospitals.

At the conclusion of the meeting, the specialty representatives were requested to report back to their parent organizations and to send to MSNJ an official statement of their policy declarations, including any formal requests or recommendations. Representatives of the specialty societies have had meetings with the New Jersey Hospital Association, the New Jersey Blue Cross, and New Jersey Blue Shield. On the basis of the information which it has thus far, the council has not been in

position to make any recommendations in this area at this time.

Recommendation

That a utilization review committee be established in each county and that the names of the chairman and other personnel be sent to the Council on Medical Services.

Approved (page 383), and urged implementation of this recommendation without delay.

Chronically Ill and The Aging*

Matthew E. Boylan, M.D., Chairman, Jersey City
(Reference Committee "F")



Inasmuch as the work of the committee is, in essence, being taken over by the considerations of Medicare, the committee has been represented in the deliberations of the Council on Medical Services by its chairman, who has participated in specific meetings to which he has been assigned. The details of the Medicare Program are reflected in the report of the Council on Medical Services.

Therefore, no meetings of the Committee on tee on the Chronically Ill and the Aging as such were held during the past year.

Approved (page 383)

Occupational Health, Rehabilitation and Workmen's Compensation*

Joseph A. Lepree, M.D., Chairman, Elizabeth
(Reference Committee "F")

Meetings were held with the acting Director of the New Jersey Department of Labor and Industry, Division of Workmen's Compensation, and with the Director and Medical Director of the New Jersey Rehabilitation Commission. These meetings resulted in the following committee recommendations, which were approved by the Council on Medical Services and the Board of Trustees:

1. That the Medical Director of the Rehabilitation Commission prepare articles for the MSNJ JOURNAL, acquainting the membership with the functions of the Rehabilitation Commission.

2. That he likewise prepare a comprehensive explanation of the Second Injury Fund also for publication in the JOURNAL.

3. That questions from members of MSNJ relating to the content of the articles be submitted to the author for possible answer through the MSNJ JOURNAL.

4. That MSNJ — with the assistance of the New Jersey Neuropsychiatric Association — cooperate with the Division of Workmen's Compensation in providing qualified physicians to make the determination of disability in those individuals who are in need of neuropsychiatric evaluation.

5. That MSNJ continue its cooperation with, and assistance to, the New Jersey Rehabilitation Commission and the New Jersey Department of Labor and Industry.

Approved (page 383)

* Special Committees to the Council on Public Health.

Public Health

John B. Fuhrmann, M.D., Chairman, Flemington
(Reference Committee "G")

The Council on Public Health has met in regular session four times to carry out its function as outlined in the Bylaws: "to study and evaluate all matters of interest to the Society in the field of public health, and to report findings and recommendations to the Board of Trustees relative to official policies and positions of MSNJ in the field of public health." The attendance at all meetings has been excellent — including those meetings of the special committees to the council. The council has worked in close liaison with the seven special committees which report directly to it — and through it to the Board of Trustees. The activities and recommendations of these committees are recorded in detail in the annual report of each committee.

Mental Health

During the past few years, it has become increasingly apparent that more and more problems in the area of public health are revolving around complex situations comprising — among other specialties — the broad scope of mental health. This situation has been amplified during the year through the work of the Subcommittee on Narcotics of the Council on Public Health. Direct focus was placed on this problem at the last meeting when the council received the recommendation from its Committee on Mental Health that the Special Committee on Mental Health be elevated to the status of an administrative council, with special committees created by it to deal with alcoholism, drug addiction, mental retardation, mental illness of children and adolescents, epilepsy, neurological disorders and psychiatric disorders of the aged. This recommendation bears much merit and has already received the support of the Society's Board of Trustees.

Approved (page 386), with the amendment of the reference committee as noted under the report of the Committee on Mental Health (page 338)

Drug Addiction Problems

The Subcommittee on Narcotics, under the chairmanship of Dr. Peter J. Guthorn, submitted a detailed report and recommendations, which were unanimously approved by the council. Since the initial study of this matter was a direct result of action by the 1964 House of Delegates, the Board shared this report with the Council on Legislation and the Council on Public Relations — to whom this matter was likewise referred. The Board deferred action on the recommendations of the subcommittee, pending study and report from the other councils. The Council on Public Relations, through the Board, gave detailed consideration to the four recommendations of the subcommittee. The Council on Public Relations approved one recommendation, did not support another recommendation, and felt it did not have sufficient knowledge or authority to act on the remaining two controversial recommendations. Thus the Board referred the entire matter back to the Subcommittee on Narcotics of the Council on Public Health for continued and extended study. This matter has been under study for two years. Perhaps more satisfactory conclusions can be reached in less time if the recommendation of the Committee on Mental Health is approved by the House.

Special Committees

Air Pollution . . . The elevation by the 1965 House of the former subcommittee on Air Pollution to the status of a special committee has been rewarding. Under the very capable leadership of Dr. Roslyn Barbash, this committee continued its excellent work. One of its most outstanding activities was the 1966 Physicians' Conference on Air Pollution, under the sponsorship of MSNJ, held on February 16 at the Clara Maass Memorial Hospital in Belleville, which was well received by all who attended.

Conservation of Vision . . . Dr. Ralph Siegel and his committee are to be commended on their outstanding work with the "Eye Start" program and the plans for its implementation throughout New Jersey.

Miscellaneous

Again this year, as Chairman of the Council on Public Health, I must express my deep gratitude to the Commissioner of Health, Roscoe P. Kandle, M.D., and to his staff for the invaluable aid they have given us in attending our meetings. Their knowledge of public health affairs throughout New Jersey is extensive, and their advice in this area is sound and courageous. Without their help, many times we would have been floundering for the proper answer to questions propounded for our consideration.

The chairmen of the special committees have been sound in their judgment this year. Their committees have functioned adequately when called upon to act. My sincerest thanks are offered to each of the committee chairmen and, also, to the members of the Council on Public Health who have worked with me this year. Without their assistance and encouragement, our work could not have been completed.

Approved (page 386)

Special Committees to the Council on Public Health

Air Pollution

Roslyn Barbash, M.D., Chairman, Teaneck
(Reference Committee "G")

Objectives



The objectives of the committee for the year have been:

1. Continuation of physician education in the field of air pollution by means of (a) health effects, (b) abatement measures, and (c) economic aspects.

2. Public Education through informed medical groups.

3. Support of abatement measures by physicians.

4. Assistance to research.

5. Support of the State Department of Health, as requested.

Air Pollution Conference

With the approval of the Board of Trustees, MSNJ — in cooperation with the New Jersey State Department of Health, the New Jersey Allergy Society, and the New Jersey Chapter of the American College of Chest Physicians — co-sponsored the second annual conference on air pollution for physicians. The conference was held on February 16 at the Clara Maass Memorial Hospital in Belleville. The session was well-attended, especially by non-physicians.

Accomplishments

Objective 1 was implemented by the air pol-

lution conference referred to above; by supplying to component societies' air pollution control committees relevant materials on conferences, legislation, and hearings; and by attendance of committee members at the AMA air pollution medical research conference, the Better Bellevue Association Conference on Air Pollution and the Lung, and other conferences.

Objective 2 was accomplished through sponsorship of public forums on air pollution in five component societies. Members of the committee have discussed this topic before school assemblies, woman's clubs, service clubs, planning boards, health officers, county boards, voluntary health groups, town managers' associations, and on radio programs. In addition, they are serving with TB and other health associations as well as citizen action groups. Educational materials for introduction into the curricula have been supplied to school administrators.

Objective 3 has been achieved through encouragement of physicians to (a) familiarize themselves with pending legislation, and (b) attend public hearings of the Air Pollution Control Commission on Chapter VIII.

Objective 4 has been implemented by establishing liaison between county air pollution committees and city respiratory disease studies. In addition, members of the committee are engaged in clinical studies involving ambient air, in which data accumulation has been aided by fellow physicians.

Objective 5 has been accomplished by means of cooperation with the State Department of Health in sponsoring the physicians' conference reported above.

Future Program

Plans for the program for the new year include: (1) re-examination of component societies' air pollution activities; (2) request for continuing supply of current material on air pollution from the United States Public Health Service; (3) study of legislation on abatement control; (4) attendance at hearings involving air pollution conducted by government bodies, both local and state.

Approved (page 386)

Cancer Control

John L. Olpp, M.D., Chairman, Englewood
(Reference Committee "G")

Tumor Registries



The 1964-65 survey of 99 general hospitals licensed by the State of New Jersey and of the 25 government hospitals revealed that 61 hospitals have Committees on Cancer *and* Tumor Registries. The American College of Surgeons requires both in the "Standards for Cancer Programs."

Although a total of 61 general and government hospitals have functioning cancer programs, only 40 have been approved by the American College of Surgeons.

The Tumor Registry at Bergen Pines County Hospital has been collecting cancer cases from all of the hospitals in Bergen County for four years and has registered 7,216 cases — 1,840 cases added in 1965. The surviving cases being followed total 4,323. This registry is serving as a pilot study in the formation and

experiences of a central registry. A detailed report of the Bergen Pines registry will be compiled after it has functioned for five years.

"Pap" Test

The Committee endorses the program of the New Jersey Division of the American Cancer Society to promote greater utilization of the "Pap" test. The Cancer Society plans to purchase cytology kits which will be distributed to physicians upon request. The kit will contain supplies sufficient for at least 10 Pap smears. The first kit will be supplied free and additional kits will be furnished, on request, at 5% over the net wholesale cost.

The Board of Trustees has approved the recommendation of the committee that MSNJ support an intensive educational program among all physicians to utilize the "Pap" test.

Recommendation

That physicians and surgeons on hospital staffs encourage and utilize the hospital cancer programs, so that more programs will meet the standards of the American College of Surgeons.

Approved (page 386)

Child Health

Robert E. Jennings, M.D., Chairman, South Orange
(Reference Committee "G")



The committee held two meetings during the year, and submits the following report of its activities.

The chairman attended the 10th National Conference on Physicians and Schools (September 23-25, 1965) in Chicago as the official representative of MSNJ. Two outstanding sessions were "The Opportunity of the School and Community in Education Related to Sex Education" and "The Role of the School and Community in Education Concerning Harmful Substances" (alcoholism, smoking, and drug addiction).

School Health Education

To implement health education in our schools, a questionnaire on school health was mailed to each district superintendent of schools in the public and parochial school systems. It is hoped that the response to the school health study questionnaire will serve as a basis for providing better liaison and productive cooperation with the State Department of Education.

In anticipation of better health education in the schools, a subcommittee is working on a model health program for use at different age levels. The subcommittee is also assembling a list of films and books dealing with sex education. These items, in final and approved form, will subsequently be available for the information of interested physicians.

The committee has interested itself in the procurement of an audio-film from the television series "Slattery's People" entitled "Do the Ignorant Sleep in Pure White Beds?". This is reported to be an excellent film presenting the problems of teenage unwed mothers, promiscuity, and the need for further sex education in the schools. The film is being obtained through the efforts of Dr. Curtis F. Culp, Director of the Division of Constructive Health, and will be reviewed for showing to parent groups.

Child Safety Activities

With the approval of the Board of Trustees, the committee urged the proclamation by Governor Hughes of Child Safety Week — April 4-10, 1966. Appropriate newspaper coverage of the proclamation was arranged with the cooperation of the Council on Public Relations.

A series of child safety bulletins has been made available by the American Academy of Pediatrics. It is the intent of the committee to obtain copies and to make them available to county committees on child health for use at local level.

Attention was called to a booklet, "Panic or Plan?", a companion to "Emergency 77," a Metropolitan Life film on precautions against accidents and illness. The committee recommended to the Board that the film and booklet have maximum usage before PTA groups, in conjunction with speakers' bureaus of county medical societies.

The committee urged each county medical society child health committee to cooperate fully with the "Eye Start" program of MSNJ.

Committee member, Dr. William Farley of Nutley, presented an exhibit on childhood accidents at the 1965 Annual Meeting. He is also completing a booklet on "The Seriously Injured Child" from material presented at MSNJ's 1963 convention.

Recommendation was made to the Board of Trustees that MSNJ urge the Departments of Health and of Education to require vaccination against measles for all children entering school. It is hoped that the departments will cooperate.

School Health Examination

The committee reaffirmed the need to amend the school health examination law (authorized by the 1958 House of Delegates). MSNJ's amendment (to authorize a school medical inspector to accept evidence of a satisfactorily performed physical examination in lieu of the required school examination), introduced in 1959 and reintroduced each year thereafter up to 1962, has not been sponsored since, because of the Society's determination to exert pressure for legislation to grant legal protection to medical and x-ray technicians carrying out certain procedures at the direction of a licensed physician.

Miscellaneous

In his capacity as liaison representative of MSNJ to the State Department of Education, the chairman attended a meeting of the Advisory Council on Education Services for Socially and Emotionally Maladjusted Pupils, held in the office of Special Education Services, New Jersey Department of Education. This council is active in dealing with many of the problems in education for this group of children.

The New Jersey Association for School Physicians was organized in May 1964 through the efforts of the committee. The first formal meeting of the association was held at New Brunswick in November 1965.

* * *

The chairman expresses appreciation for the hearty cooperation of the committee and the guidance and assistance of the secretarial staff of the Executive Offices.

Approved (page 386)

1967 Annual Meeting

Saturday, Sunday, Monday, Tuesday, Wednesday May 13-17, 1967
Haddon Hall, Atlantic City

Conservation of Hearing and Speech

Warren E. Crane, M.D., Chairman, Trenton
(Reference Committee "G")

The Committee on the Conservation of Hearing and Speech had no projects or business before it during the year. Consequently, there were no meetings scheduled.

Approved (page 386)

Conservation of Vision

Ralph E. Siegel, M.D., Chairman, Perth Amboy
(Reference Committee "G")

Eye Health Screening Program



During the week of September 19, 1965, for the ninth consecutive year, MSNJ — through its Special Committee on the Conservation of Vision — sponsored a statewide "Eye Health Screening Program." Cooperating in the program were the New Jersey Academy of Ophthalmology and Otolaryngology, The New Jersey State Department of Health, the Commission for the Blind, and the New Jersey Hospital Association.

The total number of persons screened (for the detection of eye diseases) was 10,899. Of the number screened, 4.9% were tonometry positive, or glaucoma suspects. The Eye Health Screening Program not only detects many cases of previously unsuspected glaucoma and other eye defects, but it also ranks as a leading public relations project. This year the cooperation among all participating agencies was excellent, and efficient use of community and hospital facilities was made.

The committee agreed that the increasing success of this program is indication of its importance and recommended its continuance. The Board of Trustees has approved the 10th Eye Health Screening Program, to be held during the third week of September 1966.

School Eye Symposia

Your committee, in cooperation with the Commission for the Blind, conducted in New Brunswick a well-received eye symposium for school nurses, principals, and teachers from the counties of Middlesex, Union, and Hunterdon. This symposium, which dealt with the latest aspects of visual problems among school children, was the last of a series of simular symposia held throughout the state.

Pre-School Screening Program

The committee has initiated a program for screening pre-school children for amblyopia, to be held in the public schools. The visual screening will be performed under the direction of school physicians and nurses. An ophthalmologist-in-charge has been appointed by the president of each component society as the responsible keyman to organize the screening locally.

The committee has prepared a pamphlet of instructions for personnel and mothers for use in the vision screening program for pre-school children. This pamphlet, entitled "Eye Start," is being published by the State Department of Health.

Approved (page 386)

Maternal and Infant Welfare

John D. Preece, M.D., Chairman, Trenton
(Reference Committee "G")

Maternal Deaths



The committee has been hampered in its work of classifying maternal deaths for 1965 by the delay in obtaining reports. The absence of a field physician in Essex County for a few months has resulted in the accumulation of a backlog of cases. The summaries of the committee, therefore, are not yet complete. With the cooperation of local component societies, the New Jersey State Department of Health will appoint new field physicians in those counties where the reports are not being efficiently processed.

Maternity Books

Special request has been made by the State Department of Health that the Society consider a change in format of the Maternity Service Record Books which regularly it has printed for distribution to New Jersey hospitals, upon request. The committee is satisfied that the maternity books are adequate in the form now used, with appropriate revisions. However, the committee has agreed to study the proposal of the Department of Health in detail and to ascertain the opinion of field physicians concerning it before making final recommendation to the Board.

The committee will have a joint luncheon meeting in Atlantic City with field physicians during the Society's annual meeting. At this time the committee will consider the final proposal of the State Department of Healh relative to maternity books, and will make recommendations concerning the suggestions. At this meeting, too, the committee will be in position to present final completed reports of the maternal deaths for 1965.

Approved (page 386)

Mental Health

Robert S. Garber, M.D., Chairman, Belle Mead
(Reference Committee "G",



The committee held four meetings during the year, and had informal discussions with representatives of the New Jersey State Alcoholism Control Program and the New Jersey State Drug Addiction Program. It also attempted to have a conference with a representative from the New Jersey Consultant Service for Convulsive Disorders but a mutually convenient date could not be reached.

Mental Health Steering Committee

Upon recommendation of the American Medical Association's Council on Mental Health, a mental health steering committee for New Jersey was activated two years ago. This was made up of representatives from MSNJ, the New Jersey Association for Mental Health, and the New Jersey District Branch of the American Psychiatric Association. The steer-

ing committee held one meeting during the year, but nothing conclusive has yet been determined. Thus, the committee will probably need to be re-constituted with new members for next year.

Privileged Communication

The committee continued its efforts to substantiate the necessity, especially for psychiatrists, of privileged communication. Further action in this matter will be deferred until the committee can show evidence that specific confidences have been violated with resultant real harm to patients. Upon receipt of sufficient documentary instances, MSNJ will proceed to attempt to bring about legislation which will establish privileged communication between physicians and patients in New Jersey. The committee is continuing its endeavors to accumulate such supporting materials.

Postgraduate Program

The committee has continued to encourage individuals, groups, agencies, and hospitals to foster and develop ongoing postgraduate educational programs in psychiatric matters. To this end, the committee was gratified to receive approval by MSNJ to co-sponsor with the Carrier Clinic a one-day seminar on "Psychiatry for the Physician," to be held on November 16 at the Robert Treat Hotel in Newark.

Committee Structure

The committee has been aware that, at the present time, MSNJ must deal with matters which require formation of subcommittees to the administrative councils or of special committees from other groups within the Society. It is the conviction of the committee that it could best serve the Society by elevation to the status and responsibility of an administrative council, with special committees to cover current problems as: alcoholism, drug addiction, mental retardation, mental illness of children and adolescents, epilepsy, neurological disorders, and psychiatric disorders of the aged. To this end, the committee offers the recommendation that such a council be considered. This recommendation has already received the support of the Board of Trustees.

Recommendation

That the Special Committee on Mental Health be elevated to the status of an administrative council, with special committees, as necessary, to deal with alcoholism, drug addiction, mental retardation, mental illness of children and adolescents, epilepsy, neurological disorders and psychiatric disorders of the aged.

Approved as amended by the reference committee (page 386): That the Special Committee on Mental Health be elevated to the status of an administrative council with special committes, as necessary, to deal with alcoholism, drug addicition, mental retardation, mental illness of children and adolescents, epilepsy, neurological disorders, and psychiatric disorders.

Administrative Council

Public Relations

Harry F. Suter, M.D., Chairman, Penns Grove
(Reference Committee "E")



In emphasizing its often repeated admonition that the best public relations for Medicine can be achieved by the dedicated and conscientious practicing physician, the Council looks to the individual member to do his part in the public relations efforts of MSNJ.

As the official Public Relations agency of the Society, the Council has dealt with the following activities.

Emergency Coverage

As a follow-up to the conferences held last year between representatives of MSNJ and the Attorney General with reference to the emergency medical coverage situation, the Council forwarded to the Attorney General

for his information and reference a compilation of reported county coverages and the statement of "Basic Concepts," as adopted by the 1965 House. These materials were the subject of a news release from the Attorney General, announcing that the medical profession in New Jersey had taken steps to strengthen emergency medical coverages throughout the state. He pointed out in his release that many county societies, especially in the more populous areas, had emergency plans prior to the receipt of the request from his office to MSNJ to review the situation. The news release also quoted relevant sections of the "Basic Concepts" and assured the public that the new set-up was expected to continue to insure adequate medical coverage for emergency instances.

Because of the importance for members to familiarize themselves with the "Basic Concepts," the Board approved the recommendation of the Council that the entire statement of "Basic Concepts" be included in the Appendix of Reference Information for members of MSNJ in the 1966 edition of the *Membership Directory*.

Future Physicians' Clubs

The Council agreed that advance in medical research, the rapidly increasing American population, and the public's increasing desire for medical care are some of the factors providing unlimited opportunities for physicians. The Council is aware of the trend of the nation's medical schools to strive to accelerate their already expansive programs in order to provide the additional physicians which the nation will require to care for its health needs. The Council concluded that there is a need today, more than ever, to encourage talented and conscientious students to enter the medical profession. The Council last year reviewed its previous actions concerning Future Physicians' Clubs in New Jersey. In 1960, the Council first approved the program of Future Physicians' Clubs — with the approval of the Board of Trustees — and encouraged component societies to organize and operate these groups within their county boundaries as a means of encouraging qualified young men and women to enter upon the study of medicine. In 1961, the AMA approved New Jersey's resolution recommending that all county medical societies assume active leadership in this field.

Therefore, the Council was unanimous in its desire that Future Physicians' Clubs should now exist in all counties; and that where they do not, stimulation for their establishment should be given. A questionnaire was sent to each of the component societies, soliciting detailed information about the existence of clubs under county society sponsorship. As soon as all counties have reported, the Council will organize a file and serve as a clearinghouse to assist component societies in the establishment and operation of clubs.

Medical Student Loan Fund

The suggestion of the Council that commemorative contributions to the Medical Student Loan Fund be solicited, in conjunction with the bicentennial celebration, was approved by the Medical Student Loan Fund Committee and the Board. The Council takes pride in calling attention to this most worthy endeavor of MSNJ and to the enthusiastic reception the letters of solicitation have thus far received. It calls attention to the fact that contributions will continue to be acceptable until the close of the bicentennial year, December 31, 1966.

Continuing Projects

With the approval of the Board of Trustees, the Council supervised the following continuing and special projects and activities which it routinely administers:

1. Publication and distribution of:
   a. *Junior Health Hints* (Series Three) to schools and public libraries
   b. *Health Hints* to the press, house organs, and other media, over the signature of "Michael S. Newjohn, M.D."
   c. *Membership News Letter,* including the annual compilation of a bound, indexed set to component societies
   d. *Periodic Newsletter* to cooperating agencies and individuals

2. Preparation and publication of special news releases and publicity as required from time to time in furtherance of the Society's business and interests, including:

a. 1965 Eye Health Screening Program

b. 1966 Annual Meeting

c. Child Safety Week

d. Selected official programs and activities

3. Responsibility for the bestowal of the Golden Merit Award

4. Responsibility for the press room at the Annual Meeting

5. Continuance of consultative service in support of the public relations activities of component societies

6. Encouragement of indoctrination program under the sponsorship of the component societies

7. Encouragement of statewide emergency medical care coverage, particularly with reference to the Basic Concepts Underlying the Provision of Professional Medical Care as adopted by the 1965 House of Delegates.

Drug Addiction

Since adoption by the 1964 House of Delegates of a resolution urging that MSNJ engage, in conjunction with law enforcement agencies, in a statewide educational program to prevent drug addiction, the Council has attempted to develop specific data concerning physicians and their relationships to narcotics and narcotics addiction. The Council met with representatives of the New Jersey Pharmaceutical Association, the Rutgers University College of Pharmacy, the New Jersey State Police Community Narcotics Squad, and the New Jersey Drug Addiction Program to discuss the medical and legal aspects of drug addiction. Some of the conclusions of these representatives were: (1) very few, if any, addictions result from initial medical prescriptions of drugs; (2) persons prone to experimental drugs which eventually lead to addiction are usually of psychotic nature, and inclined to live dangerously or criminally; (3) any educational program on a statewide basis should be geared for the junior and senior high school level, pointing out the dangers of experimenting with habit-forming drugs, and the responsibility of individuals to protect and control themselves against the hazards of drug addiction. In its discussions with these various representatives, the Council was assured that there has been no difficulty with the medical profession in New Jersey in connection with existing regulations governing drug addiction. Physicians are not ignorant of the laws governing drug addiction, but their limited experience in this area has not acquainted them with all the problems involved.

The Council unanimously concluded that the educational program called for in the resolution adopted by the 1964 House could be broken down into two aspects: (1) such education as may be achieved with members of the medical profession, and (2) such education as may be achieved with members of the public. The Board of Trustees approved the following recommendations in this connection, and they are here called to the attention of the membership.

1. *Education as may be achieved with members of MSNJ*

a. Encourage members to adhere to all requirements concerning the treatment and reporting of narcotic addicts.

b. Urge members, as a cooperative gesture, to assume responsibility for reporting ambulant patients who may request drugs to alleviate pain under suspicious circumstances.

c. Urge members to be careful about custody of their prescription blanks.

d. Caution members to write prescriptions in such a way as to prevent their being altered; encourage pharmacists to verify with physicians any prescription which they suspect as having been altered.

2. *Education as may be achieved with members of the public*

MSNJ make representatives available to the State Departments of Education, of Health, and Law and Public Safety, and any other agencies which may cooperate in evolving an educational program, to be used on a pilot study basis, in which physicians can participate.

The Council gave detailed study to the report and recommendations of the Subcommittee on Narcotics of the Council on Public Health, which was referred to it by the Board of Trustees. The Council took the following actions on the recommendations of the Council on Public Health as indicated:

a. The State's present program should be implemented and encouraged to the fullest. Additional personnel and facilities should be made available as needed from

less pressing tasks. The technical questions relative to the use of Methadon should be reviewed by the State Department of Institutions and Agencies.

The Council was disposed to concur in this recommendation, subject only to the development of sufficient conclusive experimental data concerning Methadon to serve as a basis for judgment.

b. Provisions for follow-up and outpatient care should not utilize Probation Officers. This is a medical problem. Most addicts are concentrated in a few densely populated areas. Existing or augmented existing facilities in these areas should be employed. State financial support of the facilities may be needed.

The Council could not support this recommendation, because — as was explained — it is impracticable. Such individuals as are involved have been convicted in courts of law and are, therefore, under jurisdiction of the courts. As criminals under suspended sentences, they are on probation and subject to the supervision of probation officers. This MSNJ is powerless to change. Probation officers are not utilized for individuals not assigned to them by the courts.

c. Private physicians under careful rules should be encouraged to treat addicts either as state or private patients. A well rounded program of counselling, therapy and medication is required. The incurable patient may require sustaining doses of drugs to keep him from desperate acts. He is a sick person dependent on drugs as the diabetic is on insulin.

d. The interpretation of the Harrison Narcotics Act brings the treating physician into conflict with the Narcotics Bureau so that many or all of the recommendations under paragraph c above may be considered illegal by them. Therefore the interpretations should be reevaluated in the face of present day knowledge and the enlarging problem. Prompt action by the Trustees is recommended.

The Council felt that it had not sufficient knowledge or authority to act on these controversial recommendations.

In carrying out the mandate of the House, the Council also made a survey to determine what films and other resource materials are available through the AMA and other agencies of the state dealing with narcotic addiction that could be used for school students. The Council has on file the resource materials, which are rather sparse.

Thus the Council has concluded that it has gone as far as its scope and function of duties will permit in addressing itself to the action of the 1964 House of Delegates.

Press Clipping Service

With the approval of the Board, the press clipping service has been re-instated for the bicentennial (200th) anniversary meeting. The Council hopes in this way to compile a permanent record of events from this celebration for the Society's historical files.

Golden Merit Award

A total of 37 members were recipients of the 1965 award, 24 of whom were present in Atlantic City. The reception immediately following the bestowal ceremonies again proved to be a highlight. With the approval of the Board, it will be continued this year. The conferral ceremony has been scheduled for 2:00 p.m. in the Rutland Room of Haddon Hall, with the reception in the Derbyshire Lounge to follow immediately. Group pictures will also be taken — in addition to individual pictures — in those instances where more than one recipient is present from the same county.

Bicentennial Coverage

Under the auspices of the Council, the convention coverage will be more extensive this year than in preceding years, in conjunction with the Society's bicentennial celebration. An official photographer has been engaged to record the activities of the convention. This coverage will be sponsored in conjunction with The Journal, whose bicentennial (July) commemorative issue will feature photographic coverage of the convention. Special facilities will be arranged for the press, and it is hoped that the bicentennial day in Atlantic City will be reflected in TV and/or radio coverage. Advance releases will be mailed from Trenton. Through the press room, information will be distributed, interviews will be arranged, and publicity pictures scheduled.

Approved (page 382)

Special Committees

Disaster Medical Care

Jack R. Karel, M.D., Chairman, Hillside
(Reference Committee "H")



In view of the Vietnam war and its escalation, the Special Committee on Disaster Medical Care has been on an alert and increased readiness status. The chairman has participated on the State Emergency Medical Services Task Group in the development of emergency plans for implementation in any disaster declared by the Governor.

The Medical Self-Help Training Program was developed to prepare the American people to take care of their own physical needs and injuries, in the event of disaster, by training one member of each household in the use of medical self-help. Because of the initiative and active cooperation of MSNJ with the State Office of Civil Defense, New Jersey ranks first in Civil Defense Region I in the Medical Self-Help Training Program and is one of the leaders in the nation. An article about the program was published in THE JOURNAL (December 1965), noting that this leadership can be maintained only with the active cooperation of every New Jersey physician who must use his influence in encouraging its wider utilization. MSNJ continously supported the anti-tetanus program and its implementation in all counties.

A paper was also published in THE JOURNAL (December 1965) on Disaster Packaged Hospitals, calling attention to the committee's conviction that they should be annexed to the established community hospitals. It is imperative that these emergency units become the responsibility of the community hospital and that physicians cooperate in the planning for their utilization. People look to their physicians to take care of the emergency needs that daily threaten them — especially as in fires, floods, explosions, hurricanes, and in man-made disasters.

Approved (page 388)

Medicine and Religion

Jerome G. Kaufman, M.D., Chairman, Maplewood
(Reference Committee "D")

The work of the Committee on Medicine and Religion has been concentrated through the year on the encouragement of activity on the part of the committees on medicine and religion established by our component societies, and in sharing in programs presented under the auspices of component societies within county boundaries. The next logical area of development is within hospitals of the state.

More and more the realization is growing that for the evaluation and solution of many of the complex problems that confront people in all walks of life today, the joint efforts of medicine and religion are necessary. Discussions within councils and committees of our Society have recognized the place for, and need of, cooperation between medicine and religion in the areas of control of drug addiction, alcoholism, venereal disease, and even traffic safety . . . to name but a few. As man does not live by bread alone, neither can he be maintained in balanced total health by medical treatment or surgical intervention unsupported by the assistance that moral principles and spiritual disciplines can afford. For this purpose our committees have been established. To this end they will continue to operate with, we hope, increasing benefit to individuals and Society alike.

Approved (page 381)

Nursing Education and Recruitment

Jesse McCall, M.D., Chairman, Newton

(Reference Committee "H")

The activity of the committee this year has centered on the activities of the Governor's Task Force on Nursing, which The Medical Society of New Jersey was influential in bringing into being. Regular meetings of the Task Force have been held, and our Society has been represented by Doctors McCall and Mulford, of the MSNJ committee, and the Society's Executive Director. In consequence of the endeavors of the committee, improved scholarship loan entitlement has been made available to nurses in training and stimulus is being supplied for the expansion of facilities for the education of nurses. The Task Force is continuing its work, and we plan to maintain close identification with it.

Approved (page 388), including the following comments of the reference committee: That the Committee on Nursing Education ond Recruitment moke overtures for the Hospitol Administrotors' Associotion or the New Jersey Hospitol Associotion to encourage increosed nursing troining facilities ond standardization to ease the burden on hospitals mointoining nursing troining schools, as compored with hospitals which maintain no nursing training schools.

Retirement Plan For Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "D")

Despite the relative quiet with relation to retirement plan this year, the committee has continued as a clearinghouse for information and study of any future changes in thinking on retirement plan for physicians. The continuance of the committee in this capacity is in accord with the recommendation approved by the 1965 House. It has not been necessary to have any formal meetings of the committee, as such, during the past year.

Approved (poge 381), including the following opinion of the reference committee: Thot the Committee on Retirement Plon for Physicions might well address itself to promotion of this plon to the membership ot lorge.

Traffic Safety

William L. Sprout, M.D., Chairman, Salem

(Reference Committee "H")



The committee received no communications during the year which required its consideration, so no meetings were held.

The chairman was notified that the Essex County Medical Society was sponsoring a Symposium on Defective Automobile Design on December 1, 1965. This information was forwarded to the Board of Trustees, with the recommendation MSNJ co-sponsor the meeting. The Board approved the recommendation, and the chairman was appointed to represent MSNJ at the symposium.

In October the chairman attended the annual meeting of The American Association for Automotive Medicine at the Mayo Clinic, and was elected secretary of that organization. Attention is called to the fact that the Medical Society of the State of New York will sponsor a resolution before the AMA House of Delegates in June 1966, supporting national legislation (S-1251) to apply safety standards to all new cars and to design and test a prototype safety car to develop new safety methods.

Approved (poge 388)

Medical-Surgical Plan of New Jersey

Nicholas F. Alfano, M.D., President, Newark
(Reference Committee "C")



A review of 1965 in terms of Medical-Surgical Plan must of necessity evoke somewhat mixed emotions. Gratification over the Plan's accomplishments — and they were considerable — is tempered by sober consideration that much still remains to be done in updating many of our policies and procedures, if we are to maintain our long-established and hitherto unchallenged leadership in the health care field.

On the plus side, the year's most noteworthy milestone was the expansion of our basic coverage without increasing subscription rates, and at the same time adopting a revised Schedule of Payments that more accurately reflects the current medical economy, as well as comparing favorably with the payment schedules of neighboring nonprofit plans.

The issuance of the new Series 1965 Subscription Certificate also provided the means of according some long-overdue recognition to the Plan's Participating Physicians. The advantage of receiving payment directly from the Plan, which was originally intended to be a perquisite of participation, had been turned to their benefit by non-Participating Physicians as well through the use of assignments. Provisions in the new Certificate stipulating that payments for services of non-Participating Physicians shall be made to subscribers, and are not assignable, restored to our Participating Physicians preferential treatment that represents a tangible benefit of participation.

Although the year-end data shows participation fractionally lower in percentage that at the close of 1965, this does not accurately reflect the very healthy upsurge that started in the latter third of the year and is still continuing. Prior to September 1, the participation ratio had dropped to its lowest point in many years, further confirming the impelling need for some of the measures referred to above.

The steady upward trend in enrollment continued in 1965, showing a gain of more than 105,000 members. With over 2.6 million subscribers and dependents enrolled at the end of the year, the Plan was covering nearly 40 per cent of the total New Jersey population and comfortably maintaining its rank as fifth largest Blue Shield Plan in the nation.

Benefits for services rendered to members also reached a new high, as did the number of cases covered. Claims incurred amounted to just under $50 million, an increase of nearly $5 million, representing 587,000 cases, a rise of more than 20 per cent over 1964.

This increased utilization had a significant impact on the Plan's financial position. An operating loss of over $1 million was sustained, and reserves were depleted by more than $1.4 million, with the year-end reserve fund standing at $3.6 million, equivalent to about three weeks of claims and operating expenses.

There is no disposition to minimize the seriousness of this situation, but certain factors bearing upon it should be pointed out.

The most important is that in a spiralling economy, the Plan has continued to operate for five years under unchanged subscription rates. To have been able to hold the line for this length of time is far from typical of most other nonprofit plans.

This appears even more unusual when one considers that during this period we have had *additional liability legislated into our coverage*. We have been required by law to pay,

benefits for eligible services rendered by lay-directed bio-analytical laboratories and certain in-hospital services rendered by dentists.

At the same time, it has been imperative that in order to remain competitive in the market the Plan initiate certain measures, such as the additional benefits previously noted, which naturally represented some increase in liability. These steps were taken with the awareness that although reserves would suffer some depletion, the Department of Banking and Insurance has shown no disposition to regard as critical a reserve situation on the order of that prevailing at year's end.

Without indulging in speculation as to what may eventuate in 1966, I believe we should be mindful that: (1) in the prevailing economy, five years is a long time to survive without an increase in rates; (2) it would be wishful thinking to believe that this can continue indefinitely; (3) our reserve position is approaching the minimal; and (4) the times dictate that further expansion of benefits is inevitable if we are to hold our own.

In regard to the last matter, it is rather ironic to note that the leadership previously established by New Jersey Blue Shield should now contribute to its ailments. One might almost say that we had too good a Plan, too soon.

The Subscription Contract introduced by our Plan ten years ago provided excellent coverage for that time and a number of years thereafter. The income limits of $5,000 single and $7,500 family were very liberal and among the highest of all Blue Shield Plans, covering about 80 per cent of our members for Service Benefits. Fee adjustments made shortly after the 1956 contract introduction brought the Plan's allowances reasonably well in line with the prevailing economy. All of these factors added up to New Jersey Blue Shield being outstanding in the country.

But the economy and the field of health care protection have changed considerably — and recently at an increasing pace — in the last decade. Largely because we were for some time ahead of the field, we did not make the frequent readjustments required of many Plans to keep up with the changing times. Our Contract continued to provide good coverage and was widely purchased, so that we did not find it necessary to issue a range of contracts, with varying coverages and at varying rates. Our one major expansion — Rider J — was, and is, accorded excellent reception. We attempted, through selected increases, to maintain an acceptable fee schedule. And during that decade it was necessary to obtain only one modest rate increase without a concurrent increase in benefits — the only one of its kind so far in the Plan's history.

But two forces that have been gathering momentum in the last few years have now emerged as compelling influences on the Plan's future.

The expanding economy has left our Service Benefits adequacy behind, tied to the earning power of ten years ago. We know that the chief strength of Blue Shield lies in its Service Benefits concept — and we also know that this strong feature is applicable today to a much smaller — and shrinking — segment of our enrolled population.

And this problem goes hand in hand with the other major development now confronting us. A quiet revolution in the purchase of health care protection has been taking place. The large-scale purchaser no longer accepts the ready-made package available to him. He hands the carrier a list of requirements and says, in effect, "Fill these, or I will obtain my coverage elsewhere." In most cases the requirements are inflexible, inasmuch as they represent benefits that have been negotiated between a union and the employer, which the employer has contracted to deliver.

These requirements represent a tremendous expansion over traditional Blue Shield coverage of just a few years ago. They have spread into many new benefit areas and new areas of dependents' eligibility. But most of all, they have expanded into new Service Benefit areas of higher income levels.

The Blue Shield paid-in-full Service Benefits concept still is of paramount importance to the purchaser — but today, he insists on full coverage for incomes as high as double those of ten years ago.

If we are going to keep moving ahead — and the only alternative is to wither on the vine — ways must be found to adapt Blue Shield to the facts of today, to remain competitive through flexibility and innovation.

In these times of decision, the Plan looks with confidence to the Medical Society for continuation of the loyal support, counsel and guidance that have sustained the Plan throughout its existence. We, in turn, pledge our utmost to the preservation and enhancement of the free enterprise system of medical practice, which Blue Shield exemplifies.

Comparative Balance Sheet December 31, 1965

Assets	*Dec. 31, 1965*	*Dec. 31, 1964*
Cash on Hand and in Banks (Working Funds)	$ 221,999	$ 301,709
Investments	15,082,780	14,883,812
Accounts Receivable:		
Subscriptions	1,109,265	602,850
Workmen's Compensation	30,605	44,142
Federal Employee Program	531,663	393,984
Miscellaneous	10,155	14,105
Accrued Interest and Dividends Receivable	166,368	133,660
Total Assets	$17,152,835	$16,374,262

Liabilities				
Claims Outstanding:				
Reported	$1,742,000		$ 821,000	
Unreported	8,770,000		7,688,000	
National Accounts	76,000	$10,588,000	9,000	$ 8,518,000
Unearned Subscriptions		2,521,430		2,358,053
Accounts Payable— Hospital Service Plan		—		145,731
Accounts Payable— Miscellaneous		389,787		277,241
Total Liabilities		$13,499,217		$11,299,025

Reserves		
Securities Evaluation	$ 452,000	$ 445,700
Special Contingent	100,000	100,000
Unassigned	3,101,618	4,529,537
Total Reserves	$ 3,653,618	$ 5,075,237
Total Liabilities and Reserves	$17,152,835	$16,374,262

Annual Statistics 1965

TABLE I

Paid 1965	*Total Services*	*% All Services*	*Payment*	*Percent*	*Payment Per Service*
Surgical	386,923	43.0%	$23,224,943	50.4%	$ 60.02
Medical	279,543	31.0	12,259,383	26.6	43.86
Obstetrical	44,743	5.0	6,241,774	13.5	139.50
Consultations	50,945	5.7	807,037	1.8	15.84
Anesthesia	137,682	15.3	3,549,210	7.7	25.78
Total	899,836	100.0%	$46,082,347	100.0%	$ 51.21

TABLE II

Distribution of Rider Services and Payment

	Total Services	*% All Services*	*Payment Amount*	*Payment Percent*	*Payment Per Service*
Surgical	24,251	16.9%	$ 530,078	17.8%	$ 21.86
Medical	4,355	3.0	254,207	8.5	58.37
Diag. X-Ray	57,923	40.3	1,292,836	43.5	22.32
Physical Therapy	4,962	3.5	126,053	4.2	25.40
X-Ray Therapy	662	0.5	92,293	3.1	139.42
Pathology	51,385	35.8	682,298	22.9	13.28
Total	143,538	100.0%	$ 2,977,765	100.0%	$ 20.75

Excludes Federal Claims Data.

TABLE III

Distribution of Earned Subscription Income		
Earned Subscription Income	$52,416,367	100.0%
Incurred Claims	49,505,321	94.5
Operating Expense	4,524,355	8.6
Underwriting Loss	1,613,309	3.1

Distribution Per Dollar of Income

	Cents
Surgical	47.6
Medical	25.1
Obstetrical	12.8
Anesthesia	7.3
Consultations	1.7
Operating Expense	8.6
Underwriting Loss	3.1

FEDERAL EMPLOYEE PROGRAM

The Plan's 1965 experience in the Federal Employee Program was about at the break even point. Enrollment decreased, claim incidence showed a decrease and operating expense went up, resulting in a very slight operating gain.

Following is a statement of income and expense, along with utilization statistics:

Income	$1,950,729	100.00%
Claims Incurred	1,866,679	95.69
	84,050	4.31
Operating Expense	83,961	4.30
Gain	$ 89	.01%

PAID BASIS

Average Exposure (Persons)	118,869
Claim Incidence per 1,000 Persons Enrolled	214
Average Cost per case	$70.89
Number of Cases	25,484
Amount Paid	$1,806,679

PUBLIC RELATIONS PROGRAM

Implementing the communications aspects of the Plan's major undertakings, which projected Public Relations activity and responsibility into broad areas of operation, made 1965 a year of added challenges. At the same time the ongoing program of achieving better recognition of the Plan's identity was given added impetus.

The most extensive communications program of the year was undertaken with the issuance of the new Subscription Certificate and Schedule of Payments. Direct mail, check stuffers, bill stuffers, internal publications, and mass media were employed in reaching subscribers of various categories, physicians, dentists, laboratory directors, group remitting agents, and the general public.

The preparation and distribution of nearly three million pieces of informational and

educational material of various types was backed up by news releases and advertisements in the general press, professional magazines, and specialty publications. "Blue Shield Pulse" and "Fast Facts" were vehicles for further dissemination. Dozens of various Plan brochures and leaflets were updated to reflect the new coverages and allowances.

In addition to the communications functions, Public Relations also participated in the drafting and review of a number of documents, including several types of Subscription Certificates, riders, and special claim forms as well as reviewing the Series 500 Schedule of Payments and Physician's Manual and preparing the Certificate transmittal to the Department of Banking and Insurance.

Almost as extensive were the Public Relations projects involved in preparing for the advent of Medicare. These included communicating with subscribers of several categories, physicians, group enrollment officials, non-enrolled Medicare-eligible persons, the Social Security Administration, Department of Health, Education and Welfare, National Association of Blue Shield Plans, and other individual Blue Shield Plans.

Continuing efforts to fix the Plans's identity more clearly in the public's mind were augmented by a series of newspaper advertisements spelling out the origin, purpose, philosophy, and function of Blue Shield and the part played by the Plan's Participating Physicians. These were subsequently reproduced, with additional text, in an attractive leaflet that was furnished Participating Physicians for distribution to patients.

A project initiated by Public Relations during the year, which is now nearing completion, should simplify for physicians and their office assistants the matter of Blue Shield coverages. A streamlined approach to the Coverage Code Guide is aimed at pinpointing, easily and quickly, any variation from standard coverage that applies to a particular patient.

The year ahead promises to be an active and demanding one, from a public relations viewpoint. Growing complexities in the field of health care protection and their impact on Blue Shield's role require increasing public relations counsel, guidance, and implementation in all spheres of Plan activity, to help maintain and increase the Plan's pre-eminence. More than ever, the public relations "team effort" made possible by the continued cooperation and support of the Medical-Surgical Plan administration and Board of Trustees will be a potent factor in the Plan's advancement.

CLAIMS INCURRED

Year	Amount
1965	$49,505,000
1964	44,717,000
1963	40,991,000
1962	37,753,000
1961	34,575,000
1960	31,516,000
1957	22,886,000
1954	13,992,000
1951	6,527,000
1948	1,204,000
1945	208,000
1942	5,000

INCIDENCE RATE PER 1,000 PERSONS ENROLLED

Year	Incidence
1965	237
1964	205
1963	193
1962	182
1961	177
1960	166
1956	143
1954	126
1951	112
1948	96
1945	86
1942	40

Physician Relations Report

During 1965, the Physician Relations Section accomplished its objective of maintaining effective communication between the Plan and its Participating Doctors, utilizing several methods. The most common avenue is still the field representatives' meetings with the medical staffs of hospitals throughout the state. A total of 74 formal hospital visits were made during 1965. The total number of physicians contacted by this method was 1,720. The average number of physicians contacted in each hospital was approximately 23. In 42 hospitals we established an information desk in the

physicians' lounge for several hours. In 32 hospitals representatives addressed physicians at regular Medical Staff Meetings. The formal presentation by the field representatives was always followed by a question and answer period which lasted anywhere from fifteen minutes to one hour. These prearranged meetings continue to be the most effective and economical facet of our field program.

In addition to hospital meetings, field representatives also conducted numerous meetings with medical assistants throughout the state — manned Plan exhibits at several medical conventions — and attended other meetings, including those of specialty societies.

During the summer months, when there is a suspension of Medical Staff Meetings and little use is made of the physicians' lounge, we concentrated our field program on office visits to physicians and their assistants.

As in previous years, a letter soliciting these visits was sent to all physicians in selected counties. This means of contact has become a valuable asset in fostering mutual good will and understanding.

We believe that the Plan's Physician Relations staff contacts with physicians serve not only to increase understanding and cooperation with the profession, but also add the human touch to relationship with a large corporation.

Enrollment Report

Medical-Surgical Plan entered 1965 with a membership total of 2,538,668 persons. At year-end 1965 this total had grown by over 105,000 members to a new high of 2,644,347 enrolled persons. During this year, one new program was introduced to the Plan's enrollment structure, namely the State Municipal Program. Introduced in early 1965, this program added 10,609 contracts representing 26,896 persons in the Plan's membership rolls.

Group business, in total, showed a net gain of 79,763 members through the 35,674 contracts added during the year. This gain was spread over all classes of coverages except the Federal Employee Program and the basic-only certificate. The trend among groups toward obtaining broader coverage through the addition of riders continued in 1965, producing a gain of 58,489 ridered contracts, or 160,903 additional persons covered for rider benefits. This naturally caused a corresponding drop in basic-only coverage, which declined by 43,883 contracts, representing 129,612 persons.

The Direct Payment categories produced a net gain of 16,032 contracts for the Plan in 1965, supplying coverage to an additional 25,916 persons. The Direct Payment Rider J Program offered to our enrolled Direct Payment population resulted in the addition of these extended benefits to the coverage of 48,500 subscribers or approximately 81,000 members. As in Group, the rider program caused the basic-only contract to suffer a reduction in exposure. The Non-Group basic-only coverage declined by 39,402 members, while the Left-Group basic-only was decreased by 12,829 members.

Armed Forces Dependents' Medical Care Program

Medical-Surgical Plan experienced its first full year of fiscal administration of payments to physicians under the government's program of medical care for dependents of U.S. uniformed services personnel.

As of July 1, 1965 Contract #DA-05-114-MD-35 was executed by the President on behalf of the Trustees of Medical-Surgical Plan of New Jersey, as was a bond in support of an advance of $100,000.

The Schedule of Allowances for the Program was negotiated between representatives of MSNJ and the U.S. Government as representing fair compensation for services rendered to patients with an annual income of $4500, the average for members of the uniformed services. Except for a reduction of anesthesia fees, the Schedule has remained unchanged since 1960. Following is the claim experience for 1965.

CLAIMS

Period	*Received*	*Declined*	*Returned Incomplete*	*Paid Claims*	*Paid Amount*	*On Hand*
Total Claims 1965.....	7,997	308	1,820	5,843	$461,512	396

Approved (page 380)

COMPARATIVE SUMMARY OF OPERATIONS

	1965		1964	
Subscriptions Earned*.....	$52,416,367	100.0%	$48,338,312	100.0%
Less:				
Claims Incurred... $49,505,321**		94.5	$44,717,063	92.5
Operating Expenses 4,524,355***		8.6	4,309,589	8.9
	54,029,676	103.1%	49,026,652	101.4%
(Loss) from Underwriting Operations..	(1,613,309)	3.1%	(688,340)	1.4%
Income on Investments.....	544,059		569,560	
Operating (Loss) for the Year.....	($ 1,069,250)		($ 118,780)	

* The gain of $4,078,055 in subscriptions earned reflects gains in enrollment, which increased by 105,679 during the year.

** The rise of $4,788,258 in claims incurred is attributable to increased exposure from larger enrollment and to increased incidence, which rose from 205 per 1,000 persons to 237.

*** The increase of $214,766 in operating expenses is caused by increased services rendered by Hospital Service Plan in the amount of $227,159 and a decrease of ($12,393) in Medical-Surgical Plan direct expenses. Based on subscriptions earned, total operating expense decreased by three tenths of one percent.

SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

	1965	1964
Reserves at January 1.....	$5,075,237	$5,619,822
Operating (Loss) for the Year.....	(1,069,250)	(118,780)
	4,005,987	5,501,042
Plus: Reserve Adjustments		
Non-Admitted Assets.....	($12,503)	($12,962)
Unrealized Capital Gains	139,434	42,474
Claim Reserve	(450,000)	(500,000)
Distribution of Prior Year's Income.....	(29,300)	44,683
	(352,369)	(425,805)
	$3,653,618*	$5,075,237

* The decrease of $1,421,619 in reserves for the protection of Plan Subscribers is caused by a net operating loss of $1,069,250 and reserve adjustments totaling $352,369.

ENROLLMENT GROWTH

Year	Enrollment
1965.....	2,644,347
1963.....	2,450,755
1960.....	2,080,582
1957.....	1,711,834
1954.....	1,196,804
1951.....	669,906
1948.....	236,604
1942.....	4,131

City of Newark Medical Plan

Effective June 1, 1965, Medical-Surgical Plan of New Jersey assumed the administrative functions of the City of Newark Medical Plan on behalf of Medical Service Administration of New Jersey. Approved services rendered from January 1, to December 31, 1965, as compared with former years, were:

Relief Year	*1960*	*1961*	*1962*	*1963*	*1964*	*1965*
Number of Cases.....	1654	1484	1151	1149	1146	1128
Value of Services.....	$7,417	$6,914	$5,329	$5,339	$5,736.50	$6,287.50
Medically Indigent						
Number of Cases.....	2553	1732	1252	1189	862	962
Value of Services.....	$11,979	$8,197	$5,999	$5,587	$4,420	$5,585

1965 BOARD OF TRUSTEES

Chairman of the Board

Thomas J. White, M.D. (1968)

First Vice President

Jerome G. Kaufman, M.D. (1967)

* Charles W. Barkhorn, M.D. (1966)
John J. Bedrick, M.D. (1966)
Robert G. Boyd (1966)
Charles L. Cunniff, M.D. (1966)
Andrew P. Dedick, Jr., M.D. (1966)
Joseph P. Donnelly, M.D. (1967)
Edgar P. Eaton, Jr. (1967)
Joseph I. Echikson, M.D. (1967)
Lloyd M. Felmly (1968)
Edwin T. Ferren, D.O. (1967)
Mortimer J. Fox, Jr. (1967)

Second Vice President

Rudolph C. Schretzmann, M.D. (1968)

Joseph M. Keating, M.D. (1967)
Elton W. Lance, M.D. (1967)
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Earl R. Mellen (1966)
Jesse McCall, M.D. (1967)
Sidney I. Simon, Ph.D. (1966)
Edward W. Sprague, M.D. (1968)
Charles O. Tyler, M.D. (1968)
Martin S. Ulan (1966)
Robert E. Verdon, M.D. (1966)
Gustave E. Wiedenmayer (1966)

ADVISORS TO THE BOARD OF TRUSTEES

	Appointed	*Term as Board Member*
F. Clyde Bowers, M.D.	1963	1961–1963
Harry N. Comando, M.D.	1959	1942–1958
William F. Costello, M.D.	1958	1948–1958
William E. Dodd, M.D.	1952	1944–1952

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D.
1945–1945
Irving P. Borsher, M.D.
1950–1965
* Theophilus H. Boysen, M.D.
1944–1945
Lewis W. Brown, M.D.
1949–1954
* William J. Carrington, M.D.
1942–1943
* Patrick H. Corrigan, M.D.
1952–1958
* Samuel A. Cosgrove, M.D.
1944–1953
William K. Harryman, M.D.
1944–1945
Sigurd W. Johnsen, M.D.
1950–1951
* Augustus S. Knight, M.D.
1942–1948
* Thomas K. Lewis, M.D.
1942–1949
* Arthur W. Lunn
1951–1962
Paul Mecray, Jr., M.D.
1953–1961
Duane E. Minard, Jr.
1957–1965
Glennis S. Rickert, M.D.
1959–1963
* Royal A. Schaaf, M.D.
1942–1964
* Norman M. Scott, M.D.
1942–1950
Reuben L. Sharp, M.D.
1950–1951
James J. Spencer, M.D.
1957–1961
John S. Thompson
1942–1965
* Carl K. Withers
1952–1961
David L. Yunich
1962–1963

* Deceased.

OFFICERS

Thomas J. White, M.D.
Chairman of the Board

Nicholas F. Alfano, M.D.
President and Medical Director

John S. Robinson
Executive Vice President

John S. Thompson
Secretary-Treasurer

N. J. PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY COUNTY

January 1, 1966

County	Total Eligible Phys.	Participating						Non-Participating						% P. P. as of 12-31-65	% P. P. as of 12-31-64
		Total	M.D.	D.O.	D.S.O.	Lab.	D.D.S.	Total	M.D.	D.O.	D.S.C.	Lab.	D.D.S.		
1. Atlantic	231	215	170	19	15	6	5	16	15				1	93.0	91.8
2. Bergen	1071	650	527	55	31	14	23	421	381	18	5	1	16	60.7	62.4
3. Burlington	222	198	154	30	8	2	4	24	19	4			1	89.1	91.3
4. Camden	633	549	361	137	29	8	14	84	74	4	3		3	86.7	86.4
5. Cape May	73	67	51	10	3	2	1	6	3	3				91.7	94.3
6. Cumberland	125	120	103	5	6	4	2	5	3	1			1	96.0	95.8
7. Essex	1687	1344	1193	49	67	16	19	343	305	8	2	4	24	79.6	79.4
8. Gloucester	132	115	75	25	9	3	3	17	13	3			1	87.1	85.9
9. Hudson	735	590	517	10	38	6	19	145	136		3	2	4	80.3	79.6
10. Hunterdon	60	55	54				1	5	5					91.6	93.2
11. Mercer	479	386	347	13	15	5	6	93	82	5			6	80.5	81.5
12. Middlesex	442	338	296	15	15	9	3	104	89	1	1	2	11	76.4	75.8
13. Monmouth	460	338	293	17	13	4	11	122	109	4	2		7	73.5	75.5
14. Morris	401	328	278	22	8	8	12	73	60	2	3	1	7	81.7	81.7
15. Ocean	156	112	96	10	3	1	2	44	41				3	71.7	76.2
16. Passaic	625	462	393	20	30	4	15	163	149	4	2	1	7	73.9	73.0
17. Salem	52	49	42	5	1	1		3	2	1				94.2	97.9
18. Somerset	151	125	113	3	3	1	5	26	22	1		1	2	82.7	75.3
19. Sussex	51	47	39	3	1	1	3	4	4					92.1	92.0
20. Union	783	551	463	33	37	7	11	232	209	7	2		14	70.3	70.4
21. Warren	53	51	47	2		2		2	2					96.2	95.9
22. Out of State	306	281	245	31	2	2	1	25	25					91.8	95.7
TOTALS	8928	6971	5857	514	334	106	160	1957	1748	66	23	12	108	78.1	78.3

N. J. PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY SPECIALTY

January 1, 1966

Type of Practice	Total Eligible Phys.	Participating						Non-Participating						% P. P. as of 12-31-65	% P. P. as of 12-31-64
		Total	M.D.	D.O.	D.S.C.	Lab.	D.D.S.	Total	M.D.	D.O.	D.S.C.	Lab.	D.D.S.		
1. Anes	362	190	180	10				172	169	3				52.4	53.7
2. Derm.-Syph	130	105	105					25	25					80.7	79.6
3. Int. Med	1077	829	817	12				248	246	2				76.9	79.0
4. Neur. Surg	41	19	19					22	22					46.3	44.7
5. Obst.-Gyn	597	295	290	5				302	301	1				49.4	46.9
6. Ophth	271	177	175	2				94	93	1				65.3	65.9
7. Orth. Surg	217	137	134	3				80	80					63.1	65.8
8. Otol	159	95	93	2				64	64					59.7	60.5
9. Path	125	101	99	2				24	24					80.8	80.0
10. Ped	450	409	408	1				41	41					90.8	91.7
11. Phys. Med	15	11	11					4	4					73.3	73.3
12. Plast. Surg	26	7	6	1				19	19					26.9	33.3
13. Analy. Labs	118	106				106		12				12		89.8	91.0
14. Proct	32	32	17	5				10	10					68.7	68.7
15. Psy. & Neuro	267	194	192	2				73	73					72.6	69.2
16. Radiology	186	144	138	6				42	42					77.4	75.7
17. Surg	727	543	531	12				184	181	3				74.6	74.7
18. Thor. Surg	17	9	9					8	8					52.9	44.4
19. Urol	159	93	91	2				66	66					58.4	52.2
20. Chiropody	357	334			334			23			23			93.5	95.3
21. General	3326	2990	2541	449				336	280	56				89.8	89.6
22. Dentists	269	161	1				160	108					108	59.8	53.6
TOTALS	8928	6971	5857	514	334	106	160	1957	1748	66	23	12	108	78.1	78.3

Approved (page 380)

Supplemental Report

Special Program Providing Liberalized Service Benefits With Augmented Fees

When the underwriting of New Jersey Blue Shield was limited to organizations wholly within our own state and virtually to a single contract form — as it was until very recently — Plan operations were relatively simple and uncomplicated. As a result, however, of the statutory extension of authority to participate in National Account underwriting, a new chapter in our corporate existence was opened. The avenues for service to the public have been greatly enlarged, and the potentials of this new field are beginning to emerge.

When a national group comes into the market for group health coverage, there must be negotiation, usually extensive, in order that:

1. The purchaser may obtain as nearly as possible the service contracts he needs and wants with a uniform scope of benefits applicable to all employees, nationwide; and

2. Each Blue Shield Plan concerned may meet the need through some adjustment of its usual benefit structure.

There is a growing tendency of National Account purchasers to specify what they want, rather than to limit their selection to the coverage immediately available. Therefore, it is inevitable that "custom made" programs will become more numerous. In most instances, the desired benefit package has been predetermined through:

1. Management and union bargaining negotiations; and

2. Dollar amount available for the agreed-upon package.

The terms specified by the buyer are transmitted to all potential carriers. In the case of Blue Shield, each Plan involved receives an invitation to participate, if possible, or to explain its inability to participate. If the benefits required differ from those of its usual benefit structure, the Plan must provide the benefits specified or risk loss of the account.

In face of the rapidly changing scope of health underwriting as briefly indicated above, the Plan's chief concern and imperative need is some degree of flexibility toward diversification. Lacking this, we are constantly confronted with the likelihood that we may continue to lose — or fail to enroll — highly desirable groups of several hundred, possibly several thousand, persons. Businesses of all kinds in this large, diversified, progressive country — still growing and continually demanding goods and services which are still in the drawing-board stage — constantly strive to satisfy the vastly changing needs, wants, and tastes of the public, subject to the varying incomes and resources of corporate and individual purchasers. We live in a world of change. Our ability to survive may depend upon our willingness to adjust with it.

The foregoing is relevant inasmuch as the Plan now is faced with a demand to provide a special national account program designed to cover a greater number of subscribers and dependents on a full coverage first dollar basis. To meet this demand the program recommended by the Plan's Board of Trustees would:

1. Provide Service Benefits under an augmented fee schedule to subscribers and dependents enrolled in such a program on the basis of the annual base hourly wage income of the employee alone, such income not to exceed $7,500 for Service Benefits entitlement;

2. Be available only to experience-rated national accounts requesting such higher level of benefits;

3. Relate payments thereunder to a special Schedule of Maximum Payments for services rendered to subscribers and dependents enrolled in the special program, such schedule to represent an increase of 15 per cent over the Plan's Series 500 Schedule for eligible services, in order to more adequately compensate Participating Physicians for services rendered under the liberalized Service Benefits income limit.

The ability to provide such a program is a matter of urgent importance to the Plan if it is to retain the enrollment of motors industry groups and affiliated organizations in New Jersey, including General Motors, Ford, Chrysler, Bendix, and Mack Truck, representing a combined Plan membership of over 100,000 persons and an annual premium of nearly $2.5 million.

The motors industry and the United Auto Workers Union have been seeking a mechanism which will provide Service Benefits in approximately 90 per cent of the covered cases. As a step in this direction, the $7,500 employee-only base hourly income limit has been established as a minimum requirement for a proposed effective date of July 1, 1966.

Many Blue Shield Plans with motors groups are preparing to provide the liberalized benefit program. Twelve Blue Shield Plans — six service and six indemnity — which cannot, or will not, provide it, have already lost their motors groups since the inception of negotiations; two large Plans — Illinois and Ohio — were eliminated prior to negotiations.

Medical-Surgical Plan is anxious to provide the program. Failure to do so by July 1, 1966 will mean that the Plan faces a serious loss of enrollment and income.

Additionally, other national accounts are expected to follow this pattern. The ability to provide such a program will allow the Plan flexibility to meet similar requirements of additional national accounts in the future.

The program under consideration takes into account the fact that liberalization of Service Benefits, utilizing a $7,500 income limit based on the hourly base wage earnings of the employee only, requires a corresponding liberalization of fees paid to Participating Physicians who extend Service Benefits under such an income limit.

After careful consideration of all aspects, and due deliberation, the Plan's Board of Trustees has recommended a 15 per cent increase in fees as adequate compensation for services rendered under the liberalized income provisions.

The recommended liberalization of Service Benefits income requirements for the special program, and the augmented fees applicable to it, will in no way affect income limits or fees in the Plan's other programs. The fee schedule increase will not adversely affect the Plan's resources, inasmuch as the groups to be enrolled under the program will be experience-rated national accounts, and hence self-sustaining.

Recommendation

The Trustees of Medical-Surgical Plan therefore **recommend** that the Trustees and House of Delegates of The Medical Society of New Jersey approve the provision by the Plan of a special program for those experience-rated national accounts which require such a program, said program to extend Service Benefits entitlement to members enrolled therein when the annual earnings of the employee only, calculated on his hourly base wage, do not exceed $7,500; and that payments thereunder to physicians rendering eligible services be governed by a special Schedule of Payments, representing an increase of 15 per cent over the Plan's Schedule of Maximum Payments — Series 500.

Approved (page 380)

The Old Helping Hand Organization

Many of the younger doctors do not know that there exists in our state a unique helping hand organization, known as the Society for the Relief of the Widows and Orphans of Medical Men in New Jersey. This organization provides immediate financial assistance to the dependents of a deceased member. It lends money without interest to assist widows and orphans of doctors who have known adversity.

For details, write to the Society at P.O. Box 95, Belleville, New Jersey.

Nominations For Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1966 annual meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6 of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

Bergen County

Victor A. Blenkle, Teaneck; Age 67
Donald B. Hull, Warwick, N.Y. (formerly Ridgewood); Age 64
Joseph T. McGuire, Verona; Age 60
Hyman Oren, Hackensack; Age 58

Burlington County

Albert Girton Kinney, Sanford, Florida (formerly Mount Holly); Age 63

Camden County

Albert H. Shafer, Cherry Hill; Age 66

Cape May County

Victor I. Barrows, North Wildwood; Age 72
Millard Cryder, Cape May Court House; Age 75
Arthur Greenleaf, Cape May; Age 76
Herschel Pettit, Ocean City; Age 81

Essex County

Samuel Baum, Bloomfield; Age 82
Julius Fechner, New Braunfels, Texas (formerly Newark); Age 72
Livingston S. Hinckley, Newark; Age 73
Herbert M. Ill, Sussex; Age 70
Louis J. Levinson, Miami, Florida (formerly Maplewood); Age 64
Jessie N. Levitt, Short Hills; Age 61
William A. Nyiri, Santa Barbara, California (formerly Newark); Age 73

Middlesex County

Philip S. Avery, New Brunswick; Age 78
Estelle E. Kleiber, New Brunswick; Age 67

Union County

Emile H. Boselli, West Franklin, N.J. (formerly Fanwood); Age 67
Frederick T. Hutton, Scotch Plains; Age 64
Irving Lerman, Asbury Park; Age 86
Abraham Weitz, Los Angeles, California (formerly Kenilworth); Age 65

Approved (page 388)

Supplemental Report

The following additional nominations for election to emeritus membership were received from the component societies:

Essex County

Nelson W. Sisson, Staunton, Virginia (formerly East Orange); age 67

Passaic County

Leon E. DeYoe, Franklin Lakes; age 76

Approved (page 388)

RESOLUTIONS

#1

Discrimination in Admission of Physicians To Units of Organized Medicine

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, a basic element in the practice of ethical medicine is adherence to the concept of the essential dignity of Man. This concept is violated when physicians discriminate against other physicians solely on the basis of race, creed, color, or national origin. Such discrimination not only is an assault upon the ethics of the medical profession, but also pushes against the overwhelming weight of scientific evidence on the nature of Man. The American Medical Association cannot afford to be an active or passive participant in such discrimination, which erodes its moral structure and divides its strength; now therefore be it

RESOLVED, that the Bergen County Medical Society records its opinion that the ethical practice of medicine includes the need for all medical societies, state and local, which are a part of the American Medical Association to admit to their full membership all qualified physicians, without regard to race, creed, color, or national origin; and be it further

RESOLVED, that the delegates of the Bergen County Medical Society at the 1966 annual meeting of the House of Delegates of The Medical Society of New Jersey be urged to work toward the passage of a resolution by that House instructing the Delegates of The Medical Society of New Jersey to the House of Delegates of the American Medical Association to introduce and/or support at the ensuing meeting of that House of Delegates an appropriate resolution to amend the Constitution of the American Medical Association to assert that membership in the American Medical Association of any constituent state association or society shall be revoked if such constituent state association or society shall allow any component society to deny full membership to any physician on the basis of race, creed, color, or national origin.

Not adopted (page 377). Recommendation of reference committee approved: That the House approve the substitute resolution of the Board of Trustees; and in consequence, that Resolution #1, #10, and #13 be not adopted.

Whereas, The Medical Society of New Jersey has, since 1870, held as its undeviating policy that "race, color, and creed are no barrier to membership, and that certified competence and character should be the only criteria for membership in any scientific body"; and

Whereas, it is alleged that membership in the American Medical Association is being denied by virtue of discriminatory practices at county and state levels; and

Whereas, there is an American Medical Association mechanism of appeal of which a rejected applicant at county and/or state level can avail himself; now therefore be it

RESOLVED, that the House of Delegates of MSNJ recommend to the House of Delegates of the American Medical Association that such changes in the Constitution and Bylaws of the AMA as are necessary be effected to assign to the AMA Judicial Council the right and responsibility to receive and act upon appeals filed by applicants who allege that they have been unfairly denied membership in county and/or state medical societies.

Adopted (page 377)

#2

Drafting Fully Licensed Doctors of Osteopathy

From the Camden County Medical Society

(Reference Committee "A")

Whereas, fully licensed Doctors of Medicine are subject to the special draft law and fully licensed Doctors of Osteopathy are exempt; and

Whereas, such Doctors of Osteopathy are engaged in the care of millions of the civilian population; and

Whereas, P.L. 89-97 gives complete and equal recognition to Doctors of Osteopathy and Doctors of Medicine; and

Whereas, Doctors of Osteopathy are not called for military medical duty, even though they are eligible for military commissions in exactly the same way as are Doctors of Medicine; and

Whereas, the military is traditionally unwilling to change its established practices without strong and repeated urging; and

Whereas, the Camden County Medical Society has actively endorsed these tenets and has approved this resolution; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey having first granted approbation to this measure, urge the Trustees of MSNJ to solicit the American Medical Association's taking whatever steps are necessary to impress upon the military that fully licensed Doctors of Osteopathy should be taken into service in exactly the same way as are fully licensed Doctors of Medicine, and that repeated strong pressure should be brought to bear until this end is accomplished.

Approved (page 377), with the following notation of the reference committee: An article appeared in the Wall Street Journal (May 4, 1966), stating that the Secretary of Defense has issued an order implementing the 1956 law that authorizes qualified osteopaths to be accepted by the Armed Forces for duty with commissions as medical officers. This fulfills the intent of the resolution.

#3

Project Hope

From the Burlington County Medical Society

(Reference Committee "B")

Whereas, Project Hope is a non-governmental non-profit organization dedicated to bringing the advantages of modern teaching methods in the practice of medicine, as we know it in the United States, to relatively underdeveloped countries around the world that are not so fortunate as our country; and

Whereas, New Jersey physicians have given their time and efforts to support this great humanitarian enterprise on an individual basis; and

Whereas, committees under the aegis of Project Hope have been formed to recruit doctors

to give their talents as well as their money to support the equipping of a sister-ship to the S.S. Hope; and

Whereas, many New Jersey physicians have a strong desire to donate their skills and teaching talents for this worthy purpose, but may be unable to do so for financial reasons; now therefore be it

RESOLVED, that The Medical Society of New Jersey use its good offices publicly to announce its endorsement and support of Project Hope; and be it further

RESOLVED, that The Medical Society of New Jersey set up a total of six (6) Fellowships, to be awarded annually, each carrying a stipend of $1,000 for a 60-day tour of duty aboard the S.S. Hope or her sister-ship; and be it further

Foregoing paragraph amended to read:

RESOLVED, that The Medical Society of New Jersey set up a maximum of six (6) Fellowships, to be awarded on a pilot basis for one year, each carrying a stipend of $1,000 for a 60-day tour of duty aboard the S.S. Hope or her sistership, and that this be reviewed annually; and be it further

RESOLVED, that these Fellowships be awarded by The Medical Society of New Jersey to those deserving and successful applicants who are either members of The Medical Society of New Jersey or Residents in approved New Jersey hospitals who are recommended for such Fellowship award by a component County Medical Society.

Approved as amended (page 379)

#4

Discontinuance of the AID Program

From the Camden County Medical Society

(Reference Committee "C")

Whereas, The Hospital Service Plan of New Jersey's AID Program was approved with misgivings by some of the delegates last year; and

Whereas, it has proved cumbersome from the standpoint of hospital administration and has resulted in delays in billing the Plan; and

Whereas, it requires certification and sometimes recertification by a physician for each patient who overstays, for whatever reason, the time limit imposed by the Plan; and

Whereas, the information requested on the form is readily available from the chart to any claims adjuster whom the Plan might send to the Record Room; and

Whereas, the Camden County Medical Society has approved this resolution at its regular March meeting and recommended that it be presented to the May 1966 meeting of the House of Delegates of The Medical Society of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey oppose continuance of this experiment and advise that the Hospital Service Plan of New Jersey re-examine its contracts with both subscriber and hospital, spelling out in the policy limits on services and showing actual payments made to hospitals instead of credits, so that an adjuster from the Plan can deal with the subscriber in an honest, dignified businesslike manner without putting the hospital or the physician in the middle as a buffer.

Disapproved (page 380). Recommendation of the reference committee approved affirming the position of the Board (page 380): That the AID program be continued for another year at least, to afford it sufficient time to prove itself.

#5

Compensation of Physicians for Care of Subsidized Patients

From John J. Reilly, M.D., Delegate from Union County

(Reference Committee "F")

Whereas, when a physician renders medical care to an indigent patient he is in essence rendering a service to the community and to the government; and

Whereas, for generations such services have been rendered by members of the medical profession without thought of recompense and have been taken for granted by the community at large; and

Whereas, changing socio-economic philosophies and practices have resulted in the government's assumption of fiscal responsibility for indigent patients; and

Whereas, in common with all other citizens physicians are being heavily taxed to support the government in this paternalistic role; and

Whereas, government freely — and sometimes excessively — compensates all other suppliers of services for which it assumes financial responsibility; and

Whereas, the Supreme Court of New Jersey has recently made formal declaration of a newly adopted policy urging the adequate compensation by government of all attorneys who render professional services to clients unable to meet such costs themselves; and

Whereas, it is unjust, unreasonable, and discriminatory to expect that only members of the medical profession should render free services to patients who are wards of government and therefore eligible for full subsidization; and

Whereas, such patients have all the resources and taxing powers of government at their disposal to meet the costs of services rendered to them and therefore can no longer claim service in charity as their due; and

Whereas, nowhere does the Hippocratic Oath, medical ethics, medical training, or medical licensure require that members of the medical profession are obligated to render services free to those who are able to pay, as wards of government certainly are; and

Whereas, precedents have already been set by the medical societies of the states of Michigan and Oklahoma, providing ordinary fees for services rendered to patients in this category; now therefore be it

RESOLVED, that The Medical Society of New Jersey embrace the policy that free professional services should be rendered by physicians only to patients who are in a state of genuine financial need and who are ineligible for assistance and support from government or any other source; and be it further

RESOLVED, that professional services rendered to patients whose health care costs are the responsibility of governmental or other agencies should be billed by physicians on their regular fee-for-service basis; and be it further

RESOLVED, that The Medical Society of New Jersey make public declaration of this policy and take whatever steps are necessary to effectuate it.

Not adopted (page 383). Recommendation of reference committee approved: That the House adopt the following substitute resolution, to cover the intent of Resolutions #5, #6, #12, and #18.

Whereas, for generations medical services have been rendered to the indigent by members of the medical profession without thought of recompense and have been taken for granted by the community at large; and

Whereas, changing socio-economic philosophies and practices have resulted in the government's assumption of fiscal responsibility for indigent patients; and

Whereas, in common with all other citizens, physicians are being heavily taxed to support the government in this role; and

Whereas, gavernment compensates all other suppliers of services for which it assumes financial responsibility; and

Whereas, the Supreme Court of New Jersey has recently made formal declaratian af a newly adopted palicy urging the compensatian by government af all attorneys wha render professianal services to clients unable ta meet such casts themselves; and

Whereas, it is unjust, unreasonable, and discriminatory to expect that only members of the medical profession should render free services to patients who are wards of government and therefore eligible for full subsidization; and

Foregoing paragraph amended by the House ta read:

Whereas, it is unjust, unreasonable, and discriminatary ta expect that anly members af the medical prafessian should render free services ta patients who are benefiiciaries af gavernment subsidies; and

Whereas, such patients, having the resources af government at their disposal, can no longer claim service in charity as their due; and

Whereas, nowhere does the Hippocratic Oath, medical ethics, medical training, or medical licensure require that members of the medical profession render services free to patients who are able to pay, as wards of government certainly are; and

Faregoing paragraph amended by the House to read:

Whereas, nowhere daes the Hippacratic Oath, medical ethics, medical training, or medical licensure require that members of the medical prafessian render services free ta patients wha are able ta pay, as benefiaries af gavernment subsidies certainly are; and

Whereas, precedents have already been set in Michigan and Oklahoma, where the medical societies have, through negatiatian, prevailed upon the civil authorities to pravide fee-far-service compensation far services rendered ta patients in this categary; now therefare be it

RESOLVED, that prafessianal services rendered ta patients whase health care casts are the responsibility of gavernment or other agencies shauld be billed by physicians an their usual and custamary fee-for-service basis; and be it further

RESOLVED, that MSNJ make public declaration af this policy by July 1966 and take whatever steps are necessary ta effectuate it.

Adopted as amended by the House (page 383)

#6

Compensation of Physicians Under Federal Tax-Supported Programs

From the Mercer County Medical Society
(Reference Committee "F")

Whereas, recently enacted Federal legislation provides full payment for many health and welfare services with free choice of physician; and

Whereas, these programs are supported by tax funds not of themselves indigent; and

Whereas, physicians heretofore usually received less than the private practice fee for medical services they provided in these programs; now therefore be it

RESOLVED, that physicians participating in these programs receive the prevailing private practice fee for the services rendered; and be it further

RESOLVED, that the appropriate governmental agencies be apprised of our stand.

Not adopted (page 383). Recommendatian af reference cammittee appraved: That the House adapt the fallawing substitute resalutian, ta cover the intent af Resalutians #5, #6, #12, and #18.

Whereas, for generations medical services have been rendered to the indigent by members of the medical prafessian withaut thought af recampense and have been taken far granted by the community at large; and

Whereas, changing socio-economic philasaphies and practices have resulted in the government's assumptian of fiscal respansibility for indigent patients; and

Whereas, in common with all ather citizens, physicians are being heavily taxed ta support the government in this rale; and

Whereas, government compensates all other suppliers of services for which it assumes financial responsibility; and

Whereas, the Supreme Court of New Jersey has recently made formal declaration of a newly adopted policy urging the compensation by government of all attorneys who render professional services to clients unable to meet such costs themselves; and

Whereas, it is unjust, unreasonable, and discriminatory to expect that only members of the medical profession should render free services to patients who are wards of government and therefore eligible for full subsidization; and

Foregoing paragraph amended by the House to read:

Whereas, it is unjust, unreasonable, and discriminatory to expect that only members of the medical profession should render free services to patients who are beneficiaries of government subsidies; and

Whereas, such patients, having the resources of government at their disposal, can no longer claim service in charity as their due; and

Whereas, nowhere does the Hippocratic Oath, medical ethics, medical training, or medical licensure require that members of the medical profession render services free to patients who are able to pay, as wards of government certainly are; and

Foregoing paragraph amended by the House to read:

Whereas, nowhere does the Hippocratic Oath, medical ethics, medical training, or medical licensure require that members of the medical profession render services free to patients who are able to pay, as beneficiaries of government subsidies certainly are; and

Whereas, precedents have already been set in Michigan and Oklahoma, where the medical societies have, through negotiation, prevailed upon the civil authorities to provide fee-for-service compensation for services rendered to patients in this category; now therefore be it

RESOLVED, that professional services rendered to patients whose health care costs are the responsibility of government or other agencies should be billed by physicians on their usual and customary fee-for-service basis; and be it further

RESOLVED, that MSNJ make public declaration of this policy by July 1966 and take whatever steps are necessary to effectuate it.

Adopted as amended by the House (page 383)

#7

Establishment of Special Committee on Alcoholism By The Medical Society of New Jersey

From the Bergen County Medical Society

(Reference Committee "G")

Whereas, the Bergen County Medical Society officially recognizes Chronic Alcoholism as a disease state; and

Whereas, The Medical Society of New Jersey approved the recognition of Chronic Alcoholism as a disease entity at its Annual Meeting in Atlantic City in May 1965; and

Whereas, through medical journals, magazine articles, press releases, and Congressional reports the people of this country, especially residents of our own State of New Jersey, have become increasingly aware of the magnitude of the problem of Alcoholism in respect to its cost in both money and human misery; and

Whereas, several bills have been introduced in both Houses of Congress which would provide matching grants to states enabling the establishment of facilities for research, treatment, and rehabilitation of Alcoholics; now therefore be it

RESOLVED, that the Bergen County Medical Society urge The Medical Society of New Jersey to establish an ad hoc Committee on Alcoholism which would be charged with the responsibility of providing leadership in a statewide effort to improve the care, treatment, and rehabilitation of the chronic alcoholic in the State of New Jersey.

No action taken (page 387). Action of the reference committee approved: The intent of this resolution has been included in the previously approved proposal for the change in structure of the Committee on Mental Health, by elevating it to an administrative council, which will establish, among other committees, one on alcoholism.

#8

Desirability of Use of Safety Lenses in Children

From the Burlington County Medical Society

(Reference Committee "G")

Whereas, needless and preventable eye accidents injure more than half a million people in this country each year; and

Whereas, eye accidents are a particular threat to children, because of mishaps at home, at school, or on the playground; and

Whereas, ordinary glasses used for correction of vision are vulnerable to shattering and have been a frequent cause of loss of vision due to imbedding of glass particles in the eye; and

Whereas, safety lenses of either shatter-resistant glass or plastic are of proved value in preventing serious eye injuries; now therefore be it

RESOLVED, that The Medical Society of New Jersey use its good offices to endorse, recommend, and publicize the desirability of the use of safety lenses of either shatter-resistant glass or plastic for all children of school or pre-school age requiring corrective lenses.

Approved (page 387), including recommendation of reference committee: That this resolution be sent to the Committee on the Conservation of Vision for study and implementation.

#9

Meeting Schedule of the House of Delegates

From the Mercer County Medical Society

(Reference Committee "H")

Whereas, for many years the House of Delegates of The Medical Society of New Jersey met on Saturday, Sunday, and completed its business on Monday, usually by noon; and

Whereas, this permitted many busy practitioners actively to participate in the transactions of the House of Delegates; and

Whereas, many valuable physicians, due to pressure of professional commitments, have been unable to attend the more prolonged meetings being conducted today; and

Whereas, the present meeting of the House of Delegates may force many delegates to go home and then return on Wednesday for the final day's meeting, and hence will increase the hardship endured by many valuable members and discourage their attendance; now therefore be it

RESOLVED, that the House of Delegates return to meeting on Saturday, Sunday, and Monday, as was the custom for many years.

Disapproved (page 388)

#10

Calling for Introduction of Amendment to Constitution of AMA Designed to Eliminate Discrimination In Organized Medicine Because of Race, Creed, or Color

From the Essex County Medical Society

(Reference Committee "A")

Whereas, the Essex County Medical Society declares that race, creed, or color have no place in the criteria for full membership in a medical organization; and

Whereas, beginning in 1939, resolutions have been proposed to the American Medical Association stating "that membership in component societies shall not be denied on the basis of race, creed or color;" and

Whereas, qualified physicians are still being denied full membership in some component medical societies because of their race, creed, or color; therefore be it

RESOLVED, that the Essex County Medical Society instruct its delegation to The Medical Society of New Jersey to introduce the following resolution at the annual meeting of the AMA House of Delegates in June 1966:

Whereas, the Medical Society of New Jersey declares that race, creed, or color have no place in the criteria for full membership in a medical organization; and

Whereas, beginning in 1939, resolutions have been proposed to the American Medical Association stating that "membership in component societies shall not be denied on the basis of race, creed, or color;" and

Whereas, qualified physicians are still being denied full membership in some component societies because of their race, creed, or color; therefore be it

RESOLVED, that The Medical Society of New Jersey instruct its delegates to the American Medical Association to introduce at the next ensuing meeting of the House of Delegates of the American Medical Association an appropriate resolution to amend the Constitution of the AMA to provide in substance that membershipship in the AMA of any constituent association or component county society shall be revoked if such constituent association or component county society shall deny full membership to any individual on the basis of race, creed or, color.

Not adopted (page 377). Recommendation of reference committee approved: That the House approve the substitute resolution of the Board of Trustees; and in consequence, that Resolutions #1, #10, and #13 be not adopted.

Whereas, The Medical Society of New Jersey has, since 1870, held as its undeviating policy that "Race, color, and creed are no barrier to membership, and that certified competence and character should be the only criteria for membership in any scientific body"; and

Whereas, it is alleged that membership in the American Medical Association is being denied by virtue of discriminatory practices at county and state levels; and

Whereas, there is no American Medical Association mechanism of appeal of which a rejected applicant at county and/or state level can avail himself; now therefore be it

RESOLVED, that the House of Delegates of MSNJ recommend to the House of Delegates of the American Medical Association that such changes in the Constitution and By-laws of the AMA as are necessary be effected to assign to the AMA Judicial Council the right and responsibility to receive and act upon appeals filed by applicants who allege that they have been unfairly denied membership in county and/or state medical societies.

Adopted (page 377)

#11

Cooperation With Medicare

From the Essex County Medical Society

(Reference Committee "A")

Whereas, Public Law 89-97, known as Medicare, has been enacted by Congress as the Law of the Land; and

Whereas, The Medical Society of New Jersey is a law-abiding, civic-minded organization; and

Whereas, one of the purposes of The Medical Society of New Jersey is to serve the public by providing a continuing high standard of medical care; and

Whereas, The Medical Society of New Jersey has accepted in the past the responsibility to confer with government agencies, third party carriers, and others to assure that, under the law and under the free enterprise concept that exists in our nation, the public will continue to receive the highest possible quality of medical care without interference with the vital personal relationship between physicians and their patients; be it therefore

RESOLVED, that The Medical Society of New Jersey agrees to cooperate and urges its membership to cooperate in the effective implementation of the Medicare Law.

Foregoing paragraph amended to read:

RESOLVED, that MSNJ continue its cooperation with those agencies involved in the implementation of P. L. 89-97, to the end that efficient and effective care may be provided consistent with the Principles of Medical Ethics.

Approved as amended (page 377)

#12

Compensation of Physicians for Care of Subsidized Patients In Hospitals

From the Gloucester County Medical Society

(Reference Committee "F")

Whereas, the Supreme Court of New Jersey has recently ruled that lawyers defending indigent clients in criminal cases must be compensated by the county freeholders at 60% of a reasonable fee ordinarily charged a paying client in a similar case; and

Whereas, many physicians in the State of New Jersey are treating medically indigent cases in hospitals day after day without any recompense; and

Whereas, physicians are being partially paid for treating such indigent patients at home or in physicians' offices (by the county welfare boards); and

Whereas, many hospitals in New Jersey do not have intern or resident staffs to treat these patients; and

Whereas, such medical, surgical, or obstetrical treatment is often of an intimate, urgent, and lifesaving nature; therefore be it

RESOLVED, that The Medical Society of New Jersey petition the county boards of freeholders and the county welfare boards to provide like compensation (i.e., 60% or more of the customary fee) for licensed physicians treating indigent patients in our hospitals; and be it further

RESOLVED, that The Medical Society of New Jersey take this proposition to the courts or the legislature, if a satisfactory answer is not forthcoming from the boards of freeholders or welfare boards.

Not adopted (page 383). Recommendation of reference committe approved: That the House adopt the following substitute resolution to cover the intent of Resolutions #5, #6, #12, and #18.

Whereas, for generations medical services have been rendered to the indigent by members of the medical profession without thought of recompense and have been taken for granted by the community at large; and

Whereas, changing socio-economic philosophies and practices have resulted in the government's assumption of fiscal responsibility for indigent patients; and

Whereas, in common with all other citizens, physicians are being heavily taxed to support the government in this role; and

Whereas, government compensates all other suppliers of services for which it assumes financial responsibility; and

Whereas, the Supreme Court of New Jersey has recently made formal declaration of a newly adopted policy urging the compensation by government of all attorneys who render professional services to clients unable to meet such costs themselves; and

Whereas, it is unjust, unreasonable, and discriminatory to expect that only members of the medical profession should render free services to patients who are wards of government and therefore eligible for full subsidization; and

Foregoing paragraph amended by the House to read:

Whereas, it is unjust, unreasonable, and discriminatory to expect that only members of the medical profession should render free services to patients who are beneficiaries of government subsidies; and

Whereas, such patients, having the resources of government at their disposal, can no longer claim service in charity as their due; and

Whereas, nowhere does the Hippocratic Oath, medical ethics, medical training, or medical licensure require that members of the medical professional render services free to patients who are able to pay, as wards of government certainly are; and

Foregoing paragraph amended by the House to read:

Whereas, nowhere does the Hippocratic Oath, medical ethics, medical training, or medical licensure require that members of the medical profession render services free to patients who are able to pay, as beneficiaries of government subsidies certainly are; and

Whereas, precedents have already been set in Michigan and Oklahoma, where the medical societies have, through negotiation, prevailed upon the civil authorities to provide fee-for-service compensation for services rendered to patients in this category; now therefore be it

RESOLVED, that professional services rendered to patients whose health care costs are the responsibility of government or other agencies should be billed by physicians on their usual and customary fee-for-service basis; and be it further

RESOLVED, that MSNJ make public declaration of this policy by July 1966 and take whatever steps are necessary to effectuate it.

Adopted as amended by the House (page 383)

#13

Discrimination in Admission of Physicians To Units of Organized Medicine

From the Hudson County Medical Society
(Reference Committee "A")

Whereas, the Hudson County Medical Society has repeatedly stated that race, creed, or color has no place in the criteria for membership in a medical organization; and

Whereas, resolutions were proposed to the American Medical Association stating "that membership in component societies shall not be denied on the basis of race, creed, or color"; and

Whereas, qualified physicians are still being denied membership in some component medical societies because of their race, creed, or color; therefore be it

RESOLVED, that the Hudson County Medical Society instruct its delegates to The Medical Society of New Jersey to introduce a resolution to amend the Constitution and Bylaws of the American Medical Association at the next Annual Meeting as follows:

Membership in the American Medical Association of any constituent association shall be revoked if such constituent association shall allow any component society to deny membership to any individual on the basis of race, color or creed.

Nat adapted (page 377). Recammendatian of reference cammittee appraved: That the Hause approve the substitute resolution af the Board af Trustees; and in consequence, that Resolutions #1, #10, and #13 be nat adopted.

Whereas, The Medical Society af New Jersey has, since 1870, held as its undeviating policy that "Race, calor, and creed are no barrier to membership, and that certified competence and character should be the only criteria for membership in any scientific body"; and

Whereas, it is alleged that membership in the American Medical Associatian is being denied by virtue af discriminatary practices at caunty and state levels; and

Whereas, there is na American Medical Assaciatian mechanism af appeal af which a rejected applicant at caunty and/or state level can avail himself; naw therefore be it

RESOLVED, that the Hause of Delegates of MSNJ recammend ta the Hause af Delegates af the American Medical Association that such changes in the Canstitutian and Bylaws af the AMA as are necessary be effected to assign to the AMA Judicial Cauncil the right and respansibility to receive and act upan appeals filed by applicants who allege that they have been unfairly denied membership in county and/ar state medical sacieties.

Adapted (page 377)

#14

Voluntary AMPAC and JEMPAC Billing

Withdrawn by the sponsors. (page 379)

#15

Separation of Professional Fees and Hospital Charges

From John J. Thompson, M.D., Delegate, Essex County and
Arthur Kratzman, M.D., Delegate, Union County

(Reference Committee "C")

Whereas, the Medicare program has provided for the payment of hospital service charges in behalf of those eligible persons 65 years of age and over, said payment to be financed through Social Security taxes; and

Whereas, the Medicare program also provides for the payment of professional medical fees on a voluntary contributory basis for those eligible to participate; and

Whereas, many in-hospital services, including radiological services, have been billed to the patient as a hospital charge even though the total charge has been made up of both hospital services and professional medical services; and

Whereas, billing under the Medicare program will require a separation of hospital services from professional medical services; and

Whereas, the Board of Trustees and the House of Delegates of The Medical Society of New Jersey have stated the position of MSNJ that Anesthesiology, Radiology, Physiotherapy, and Clinical Pathology are branches of the practice of medicine and have communicated this position to the New Jersey Hospital Association in the years 1947, 1956, 1957, and 1959; and

Whereas, The Medical Society of New Jersey through its House of Delegates has announced as the position of MSNJ that hospital-based specialists are private practitioners of medicine and that their compensation for professional services should be on a fee for service basis, said position having been announced in 1951, 1954, 1957, 1958, 1959, and 1962; and

Whereas, The Medical Society of New Jersey has approved the exclusion of hospital-based professional medical services from the contracts of the Hospital Service Plan of New Jersey and the inclusion of such services within the contracts of the Medical-Surgical Plan of New Jersey, and announced such approval in 1952, which approval was affirmed by the House of Delegates in 1956, 1957, and 1959; now therefore be it

RESOLVED, that The Medical Society of New Jersey strongly urge the Medical-Surgical Plan to contact the Hospital Service Plan immediately to effect the inclusion of hospital-based professional medical services within the contracts of the Medical-Surgical Plan of New Jersey and the exclusion of such services from the contracts of the Hospital Service Plan of New Jersey, with as little as possible inconvenience or cost to the Plans' subscribers; and be it further

RESOLVED, that the Medical-Surgical Plan cooperatively report to the Board of Trustees of The Medical Society of New Jersey concerning its progress toward attainment of this end; and be it further

RESOLVED, that the members of the Board of Trustees and of the House of Delegates of MSNJ cooperatively make themselves available, to further the implementation of this transfer of coverage.

Approved (page 380), including recommendation of the reference committee: That the present wording be accepted as a basis for the start of negotiations with this proviso.

#16

The Ethics of Individual Responsibility

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, quality medical care can only be assured by maintaining the fundamental principles of the patient-physician relationship free from the influence of third parties; and

Whereas, this is embodied in the Principles of Medical Ethics of the American Medical Association, Section VI, which reads: "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care"; and

Whereas, this is also embodied in the principle of individual responsibility, wherein the physician is responsible to the patient for all aspects of rendering medical care, to the best of his ability; and the patient is responsible to the physician for obtaining and providing for payment of the fair cost of medical care; and

Whereas, the acceptance of benefits from a fiscal intermediary has posed in the past, and will continue to pose, a distinct threat to this patient-physician relationship, and can result in deterioration of quality medical care; and

Whereas, an Attending Physician's Statement is reasonable and adequate for reports of medical services to patients for reimbursements, and also serves as a "direct billing" mechanism (thus eliminating third party interference in the doctor-patient relationship); now therefore be it

RESOLVED, that the Bergen County Medical Society endorse and approve the ethics and the principle of Individual Responsibility in the distribution of medical services by physicians; and be it further

RESOLVED, that the principle of Individual Responsibility be well sustained by an adequate statement or report by the attending physician, recognized as an ethical means for use by those physicians who voluntarily decide to use it; and be it further

RESOLVED, that all members of The Medical Society of New Jersey be informed by the Board of Trustees of this action, with supporting information; and be it further

RESOLVED, that the House of Delegates of The Medical Society of New Jersey request its delegation to the American Medical Association to introduce and support this resolution at the next meeting of the House of Delegates of the American Medical Association.

Rejected (page 384). Recommendation of the reference committee rejected by the House: That the fourth whereas be deleted and that this resolution as amended by that deletion be adopted.

Facts About Arthritis

Your patient can get a copy of the authoritative, hopeful, and readable pamphlet, *Facts about Arthritis,* from the Arthritis Foundation at 1212 Avenue of the Americas, New York City 10036. There is no charge for a single copy. Prepared by the Foundation under close medical supervision, it answer the patient's questions in straightforward, sensible fashion.

#17

Expansion of Medical School Facilities

From A. Guy Campo, M.D., Delegate, Gloucester County and
Nicholas E. Marchione, M.D., Delegate, Cumberland County

(Reference Committee "F")

Whereas, it has become increasingly evident that there is a shortage of interns in the intern-accredited hospitals of New Jersey; and

Whereas, according to the matching plan, the thirty-nine hospitals in New Jersey accredited for internship should have had 547 interns during the year ending July 1, 1966; and

Whereas, these hospitals had only 74 graduates accepting these accredited internships — this being only 13½% of the quota filled — lowest percentage of any state; and

Whereas, this shortage will undoubtedly be reflected in the efficient operation of our accredited hospitals and also in the number of physicians locating in New Jersey; and

Whereas, there has been an apparent increased resistance by medical schools in other states accepting New Jersey residents; and

Whereas, our New Jersey College of Medicine graduates approximately 85 to 90 per year; therefore be it

RESOLVED, that:

(1) The New Jersey College of Medicine be expanded to graduate more students.

(2) Rutgers Medical School expand not only to increase the number of students accepted, but plan to become a four year medical school . . . immediately.

(3) A third medical school be planned for New Jersey; and be it further

Foregoing RESOLVED amended to read:

RESOLVED, that New Jersey medical schools receiving tax monies be urged to expand their enrollments; and be it further

RESOLVED, that a third medical school be planned for New Jersey; and be it further

RESOLVED, that The Medical Society of New Jersey take steps to promote this expansion of medical education in New Jersey and that a copy of this resolution be forwarded to the Governor and the legislators for implementation.

Adopted as amended (page 384)

1965 TRANSACTIONS

At its first session on Saturday afternoon, May 14, 1966, the House of Delegates:

(1) Approved the Transactions of the 1965 House of Delegates as published in the July 1965 issue of THE JOURNAL and distributed to the membership.

(2) Approved the Transactions of the special meeting of the House of Delegates (held on November 14, 1965) as published in the December 1965 issue of THE JOURNAL and distributed to the membership.

#18

Compensation of Physicians for Care of All Patients

From the Bergen County Medical Society

(Reference Committee "F")

Whereas, various segments of the population; and

Whereas, all patients—whether Welfare, Medicare, Title 19, or private patients — are entitled to the same quality medical care; and

Whereas, physicians should not be differentiated from any other vendors rendering private services to an individual; now therefore be it

RESOLVED, that physicians are entitled to the usual customary and equal compensation for the care of all patients, regardless of categories — whether Welfare, Title 19, Medicare, or private patients; and be it further

RESOLVED, that a copy of this resolution be presented for action and adoption by the House of Delegates at the annual meeting of The Medical Society of New Jersey by the delegates of Bergen County; and be it further

RESOLVED, that the New Jersey Delegates to the American Medical Association be instructed to introduce this resolution for action to the AMA House of Delegates.

Not adopted (page 383). Recommendation of reference committee approved: That the House adopt the following substitute resolution, to cover the intent of Resolutions #5, #6, #12, and #18.

Whereas, for generations medical services have been rendered to the indigent by members of the medical profession without thought of recompense and have been taken for granted by the community at large; and

Whereas, changing socio-economic philosophies and practices have resulted in the government's assumption of fiscal responsibility for indigent patients; and

Whereas, in common with all other citizens, physicians are being heavily taxed to support the government in this role; and

Whereas, government compensates all other suppliers of services for which it assumes financial responsibility; and

Whereas, the Supreme Court of New Jersey has recently made formal declaration of a newly adopted policy urging the compensation by government of all attorneys who render professional services to clients unable to meet such costs themselves; and

Whereas, it is unjust, unreasonable, and discriminatory to expect that only members of the medical profession should render free services to patients who are wards of government and therefore eligible for full subsidization; and

Foregoing paragraph amended by the House to read:

Whereas, it is unjust, unreasonable, and discriminatory to expect that only members of the medical profession should render free services to patients who are beneficiaries of government subsidies; and

Whereas, such patients, having the resources of government at their disposal, can no longer claim service in charity as their due; and

Whereas, nowhere does the Hippocratic Oath, medical ethics, medical training, or medical licensure require that members of the medical profession render services free to patients who are able to pay, as wards of government certainly are; and

Foregoing paragraph amended by the House to read:

Whereas, nowhere does the Hippocratic Oath, medical ethics, medical training, or medical licensure require that members of the medical profession render services free to patients who are able to pay, as benefiaries of government subsidies certainly are; and

Whereas, precedents have already been set in Michigan and Oklahoma, where the medical societies have, through negotiation, prevailed upon the civil authorities to provide fee-for-service compensation for services rendered to patients in this category; now therefore be it

RESOLVED, that professional services rendered to patients whose health care costs are the responsibility of government or other agencies should be billed by physicians on their usual and customary fee-for-service basis; and be it further

RESOLVED, that MSNJ make public declaration of this policy by July 1966 and take whatever steps are necessary to effectuate it.

Adopted as amended by the House (page 383)

#19

Individual Responsibility Program

From the Ocean County Medical Society

(Reference Committee "F")

Whereas, quality medical care can only be assured by maintaining the fundamental principles of the patient-physician relationship free from the influence of third parties; and

Whereas, this tenet is embodied in the Principles of Medical Ethics of the American Medical Association, Section VI, which reads "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care;" and

Whereas, this tenet is embodied in the principles of individual responsibility wherein the physician is responsible to the patient for all aspects of rendering medical care to the best of his ability; and the obtaining and providing for the payment of medical care are the primary responsibilities of the individual citizen; and

Whereas, the acceptance of benefits from a fiscal intermediary has posed in the past, and will continue to pose, a distinct threat to this patient-physician relationship and can result in deterioration of quality medical care; and

Whereas, the attending physician's statement of individual responsibilities is reasonable and adequate for reports of medical services to patients for reimbursements and serves as a "direct billing" mechanism; thus eliminating third party interference in the "Doctor-Patient" relationship; now, therefore be it

RESOLVED, that the Ocean County Medical Society, May 11, 1966, endorses and approves the ethics and the principle of Individual Responsibility in the distribution of medical services by physicians; and be it further

RESOLVED, that the principle of individual responsibility is well sustained by an adequate statement or report by the attending physician, recognized as an ethical means for use by those physicians who voluntarily desire and decide to use it; and be it further

RESOLVED, that the Ocean County Medical Society request its delegation to the New Jersey State Medical Society to introduce and support this resolution at the next meeting of the House of Delegates of MSNJ.

Not approved (page 384). The House adopted the recommendation of the chairman of the reference committee: That, in consequence of the action of the House on Resolution #16, Resolution #19 be not approved.

The Most Dangerous Day

According to the Travelers Insurance Company (and they ought to know), Saturday is the most dangerous day in the week for automobile drivers and passengers. Some 22 per cent of all fatal accidents occurred then; and 19 per cent occurred on Sundays. So between these two days, weekends accounted for 41 percent of all automobile fatalities, though, their share by chance distribution would have been only 29 per cent. And the most dangerous hours—any day in the week—are between 5 p.m. and 8 p.m. *Verbum sap.!*

#20

Urging the Creation in New Jersey of Top-Level Health Care Planning and Administrative Groups for the State as a Whole and for Its Various Subdivided Health "Regions"

From John Winslow, M.D., Delegate from Essex County
(Reference Committee "F")

Whereas, careful planning and administration of health care now constitute a great and crying need because of recent national legislative developments; and

Whereas, at the state level, as in New Jersey, there are many different agencies and departments of state government which are concerned with the overall organization and provision of health care; and

Whereas, it is only logical that any real cooperation among these agencies and departments cannot and never could be expected because of their present ingrained organizational structure, thereby bringing the result that short or long term health care planning and administration of any real meaning are impossible; and

Whereas, federal regulation of health care should be in the form of guidelines rather than that of actual basic administration and planning at the state and local level; and

Whereas, this problem of the need for coordinated planning and administration at the state and local level is being more and more recognized as urgent by such important groups as the National Commission on Community Health Services, whose preliminary final report was made public at the recent National Health Forum in New York City; and

Whereas, this urgent need for proper state and local planning is the subject of impending national legislation in the form of Senator Hill's bill, S.3008, "Comprehensive Health Planning . . . Amendments of 1966," which would give aid and assistance to each state in setting up a new overall state agency which it would require, and through which all federal funds for health care would be channeled. It would also require that this new agency have an advisory body to it, which body would be truly representative. S.3008 would also give funds to help planning and coordinating agencies at the local community "region" level, provided that these groups are given sufficient powers; and therefore be it

RESOLVED, that The Medical Society of New Jersey urge the Governor and/or the Legislature of the State of New Jersey to issue an early call for a statewide conference which would be truly representative of the administrators, consumers, and providers of medical care, this conference being the *first step* toward the better organization and provision of health care in New Jersey. This would lead to the *second step,* namely the establishment of an advisory council on overall health planning which would be responsible, initially, to the Governor and/or the Legislature and, later, to whatever special overall state administrative agency or department would be created, this being the *third step,* for the coordinated administration of all federal and state financed health care functions and whatever other duties it might be given; and be it further

RESOLVED, that The Medical Society of New Jersey urge that the Governor and/or the Legislature not wait for the first two steps outlined above but immediately go forward with the needed planning for the third, which is the overall state administrative agency or department; and be it further

RESOLVED, that The Medical Society of New Jersey again urge its component county societies to help organize and become thoroughly involved in the establishment of

planning and administrative groups for their local areas, meaning such areas as the recently announced hospital facilities planning "regions," and further urge that the guidelines for these new groups be broad enough to encompass planning for all medical care, not just the narrower limits of hospital and certain types of associated "welfare" agency care. It should urge that truly representative groups be set up at the local level with the involvement of all types of administrators, consumers, and providers of medical care, and the county medical societies should make sure that they are officially and conscientiously represented at all levels; and be it further

RESOLVED, that The Medical Society of New Jersey again urge all its members to become thoroughly cognizant of the various planning groups in their area and their problems, and that the members become personally involved when possible in order to give the benefit of their experience and advice, to the effect that the best and most sensible medical care can be provided according to good medical judgment.

Approved **(page 385)**

#21

Urging the Passage of Implementing Legislation for Title XIX

From John Winslow, M.D., Delegate from Essex County

(Reference Committee "F")

Whereas, there is included in Public Law 89-97 (which was passed by the United States Congress in 1965) a certain section of medical assistance legislation known as Title XIX, "Grants to the States for Medical Assistance Program"; and

Whereas, Title XIX provides reimbursement for the medical care of "medically indigent" persons, as determined by criteria established by the Federal Government in consultation with each individual state as it passes the enabling legislation; and

Whereas, New Jersey has many "medically indigent" persons who are too young for regular "Medicare" coverage under Title XVIII and often do not seek necessary medical care through inability to finance it, or are getting insufficient or relatively poor quality care under the present "welfare" methods of inadequate financial support; and

Whereas, Title XIX gives every evidence that it will be much more far-reaching than even Title XVIII (Medicare) in its effects for good or bad on the practice of medicine as we know it, and, therefore, requires that this legislation get most careful consideration from all angles in the drawing up of its enabling statutes; and

Whereas, the New Jersey Legislature has not yet passed the needed enabling legislation for Title XIX, though it will be required to do so within the next several years or face the mandatory loss of all federal grants under current programs such as OAA & MAA; now therefore be it

RESOLVED, that The Medical Society of New Jersey, through its Trustees, acting via proper channels, urge the Legislature of the State of New Jersey to begin the necessary preliminary studies toward the early passage of the enabling legislation for Title XIX; and be it further

RESOLVED, that The Medical Society of New Jersey take every opportunity to participate in the planning and development of said enabling legislation, thereby helping to make sure that proper and sensible safeguards are incorporated in it to avoid misuse and abuse while retaining the goal that there will no longer be any "poor" insofar as good medical care is concerned.

RESOLVED, that MSNJ strongly recommend the selection of Blue Shield and Blue Cross as fiscal intermediaries or administrators.

Adopted as amended **(page 385)**

REFERENCE COMMITTEES

Reference Committee "A"

Henry J. Mineur, M.D., Chairman

Reference Committee "A" met on Sunday, May 15, 1966, with all members present: Doctors Charles L. Cunniff, William J. D'Elia, Adolph R. Wichman, Robert G. Stineman, and the chairman. Approximately 25 delegates and members were present to discuss the various items under consideration.

1. **President** (page 283)

The report of the President was reviewed. We commend him for the time and effort he has extended in the affairs of the Society in the past year, and for his precise and comprehensive report.

The committee *recommends* approval of the report of the President.

Adopted

2. **Board of Trustees** (page 291)

The introductory portion of this report, covering the general activities of the Board, was reviewed and approved. The committee notes and commends the members of the Board for their almost perfect attendance record.

The committee *recommends* approval of this portion of the report.

Adopted

A. **Professional Liability Panel** (page 291)

The committee notes that the Board fulfilled the mandate of the 1965 House of Delegates and that the Professional Liability Panels are now being set up.

The committee *recommends* approval of this portion of the report.

Adopted

B. **Committee Structure** (page 291)

The ad hoc committee continues its studies toward the consolidation, deletion, and streamlining of committee structure.

The committee *recommends* approval of this portion of the report.

Adopted

C. **Public Relations Personnel** (page 292)

The Board of Trustees continues in its efforts to secure public relations personnel to assist the Executive Director as approved by the 1965 House of Delegates.

The committee *recommends* approval of this portion of the report.

Adopted

D. **Special Meeting of House of Delegates** (page 292)

The committee *recommends* approval of this portion of the report.

Adopted

E. **Conference of County President** (page 292)

The presidents of the component societies again met twice with the Board of Trustees this past year.

Extensive discussion at the reference committee meeting, of material from these meetings, raised the following points which the committee wishes to stress:

(1) There is a great increase in the amount of information to be transmitted between individuals and organizations at county, state, and national levels.

(2) Effective communications require that there be both sending and receiving of information.

(3) Adequate channels for communication and action exist within the structure of organized medicine.

(4) There are hazards in the presence of parallel lines of authority if those lines are not defined precisely.

(5) There is need for greater participation by individuals and component societies in efforts to improve communications.

(6) It is important that physicians take more active roles in regional planning committees and as members of boards of health.

(7) The matter of unit voting by component society delegations is to be determined by the component society in its bylaws.

The committee *recommends* approval of this portion of the report.

Adopted

F. **AMA Proposed Membership Dues Increase**
Supplemental Report (page 298)

In response to the formal opposition to the proposed $25.00 AMA dues increase, the Board of Trustees sent representatives to Chicago to evaluate the fiscal facts presented to justify the increase. As a result of these studies, the Board of Trustees proposes that instead of a $25.00 dues increase there be a one-time special assessment of $10.00 to raise the AMA operating reserve. Disbursements from this fund would be subject to explicit action of the AMA House of Delegates.

The reference committee commends the Board of Trustees for its diligent and detailed study and *recommends* approval of this portion of the report.

Adopted

G. **Discrimination in Admission of Physicians to Units of Organized Medicine**
Supplemental Report (page 298)

There was extensive discussion of methods for the prevention and correction of discriminatory practices which deny qualified physicians membership in local societies solely for reasons of race, creed, and color.

Three resolutions from component societies and a substitute resolution from the Board of Trustees were considered in detail. The three resolutions from the component societies all call for the expulsion from the AMA of local societies found guilty of racial discrimination. The Bylaws of The Medical Society of New Jersey (Chapter VII; Section 7) provide that an applicant excluded from membership by a county society may appeal to the Judicial Council. It is this provision which the Board of Trustees suggests the AMA adopt. The committee feels that this is a constructive and desirable proposal that would develop specific documentation of current cases of alleged discrimination.

The committee *recommends* approval of the substitute resolution and that in consequence, Resolutions #1, #10, and #13 be not adopted.

Adopted

3. Secretary (page 284)

The committee commends the Secretary for his activities and *recommends* approval of his report.

Adopted

4. **Judicial Council** (page 300)

The committee wishes to stress to the delegates that the Judicial Council considers only those questions relating to ethics and professional conduct and not those relating to alleged violation of law. It should also be noted that it is incumbent upon each physician to be familiar with the Code of Ethics since ignorance of the Code will not release him from liability before the Judicial Council.

The Judicial Council encourages continued cooperation in the processing of complaints at county level.

The committee *recommends* approval of this portion of the report.

Adopted

5. **Executive Director** (page 302)

The committee commends the Executive Director for his diligence and efficiency in the direction of the affairs of the Society. We suggest that all delegates read the addendum to his report, which is a summary of the activities of The Medical Society of New Jersey pointing up the broad scope and complexity of the Society's endeavors.

We *recommend* approval of this portion of the report.

Adopted

6. **Credentials** (page 307)

The committee *recommends* approval of this portion of the report.

Adopted

7. **Resolutions**

A. Discrimination in Admission of Physicians to Units of Organized Medicine — Resolution #1 (page 357), Resolution #13 (page 367), and Supplemental Report of the Board (page 298)

B. Calling for Introduction of Amendment to Constitution of AMA Designed to Eliminate Discrimination in Organized Medicine Because of Race, Creed, or Color — Resolution #10 (page 364)

The above resolutions are dealt with in item G. under the report of the Board of Trustees.

C. Drafting Fully Licensed Doctors of Osteopathy — Resolution #2 (page 358)

The committee was informed that an article appeared in the *Wall Street Journal,* May 4, 1966, stating that the Secretary of Defense, Mr. McNamara, has issued an order implementing the 1956 Law that authorizes qualified osteopaths to be accepted by the Armed Forces for duty with commissions as medical officers. This fulfills the intent of the Resolution.

The committee *recommends* approval of Resolution #2 for the purpose of the record.

Foregoing paragraph amended to read: The committee recommends approval of Resolution #2.

Adopted as amended

D. Cooperation With Medicare — Resolution #11 (page 365)

The committee questions the need for this resolution as written and was disturbed by the ambiguous nature of the last paragraph. We suggest the following revision of the last paragraph for purposes of clarification:

"RESOLVED, that MSNJ continue its cooperation with those agencies involved in the implementation of P.L. 89-97 to the end that efficient and effective care may be provided consistent with the Principles of Ethics."

The committee *recommends* approval of the resolution as amended.

Adopted

The committee *recommends* approval of the report as a whole as amended.

Report as a whole adopted as amended

Reference Committee "B"

Henry O. vonDeilen, M.D., Chairman

Reference Committee "B" met on Sunday, May 15, 1966, with all members present: Doctors John P. O'Connor, Matthew E. Boylan, Isaac N. Patterson, George J. Kohut, and the chairman. Approximately 9 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees — Items**

Academy of Medicine of New Jersey (page 299)

This item was discussed and recommendations will be made under the item of Finance and Budget.

Adopted

2. **Treasurer** (page 285)

The committee reviewed the detailed report. Several items were discussed with Dr. Featherston and members of the committee. All items were explained to the satisfaction of everybody present. The reference committee, as in previous years, was impressed with the thoroughness and details of the Treasurer's report and commended the Treasurer for a job well done and *recommends* that the report of the Treasurer be approved.

Adopted

3. **Finance and Budget** (page 308)

The report of the Committee on Finance and Budget was reviewed and found to be concise, detailed, and very illuminating. The increase of the budget of approximately $30,000 was explained as mostly increases in salaries of the staff.

A. The Journal

We commend the operation of THE JOURNAL and notice that the deficit has been decreased and commend them on a job well done. We *recommend* that this section be approved as presented.

Adopted

B. Special Per Capita Assessment

We *recommend* that the House of Delegates vote a special per capita assessment of $5.00, to serve as a contribution to the Medical Student Loan Fund to be available for loans in 1966-67 (50%); to the bicentennial fund (25%); and to the Library of the Academy of Medicine of New Jersey (25%); and that this assessment not be a part of the budgetary assessment, but that it be billed at the same time.

Adopted

C. Academy of Medicine of New Jersey

The committee *recommends* that the House of Delegates postpone the disbursement to the Library of the Academy of Medicine of New Jersey of any surplus monies from the Bicentennial Fund until such time as the bicentennial financial situation is reviewable, to determine the amount of these surplus monies (after December 31, 1966).

Adopted

D. 1967 Assessment

The committee *recommends* that the 1967 assessment be adopted at $40.00 per capita, with no provision for a contribution to AMA-ERF.

Adopted

E. 1966-67 Budget

The committee *recommends* that the 1966-67 budget be adopted in the total sum of $281,-339.00.

Adopted

We *recommend* that the report of the Finance and Budget Committee be approved as presented.

Adopted

4. **Medical Student Loan Fund** (page 315)

The reference committee *recommends* approval of this report on the activities of the Society's Medical Student Loan Fund and extends its personal thanks to Dr. Mulligan and his committee for their efforts in behalf of furthering medical education by making the economic stress and strain more endurable for medical students. The committee suggests that measures be taken by the Medical Student Loan Fund Committee to see that recipients of loans will intern in New Jersey hospitals.

Adopted

5. **Publication** (page 318)

The reference committee was impressed with the zeal and effort of the Publication Committee in its efforts to reduce operating expenses and still publish a better and more informative JOURNAL. We commend Dr. Sharbaugh, Dr. Davidson, Miss Goeke, and the Publication Committee for presenting a pleasing, educational, and readable publication. We *recommend* approval of the report of the Publication Committee.

Adopted

6. **Resolutions:**

A. **Project Hope** — Resolution #3 (page 358)

Resolution #3 was thoroughly discussed. With the consent of the member of the Burlington County Medical Society, one section of the second "Resolved" was reworded to read as follows:

RESOLVED, that MSNJ set up a maximum of six (6) Fellowships, to be awarded on a pilot basis for one year, each carrying a stipend of $1,000 for a 60-day tour of duty aboard the S.S. Hope or her sister-ship, and that this should be reviewed annually; and be it further

We therefore *recommend* that Resolution #3 be approved, as amended.

Adopted

B. **Voluntary AMPAC and JEMPAC Billing** — Resolution #14 (page 367)

The chairman informed the committee that Resolution #14 was withdrawn by the sponsors. Therefore, it was not discussed.

Report adopted as a whole

Reference Committee "C"

Andrew C. Ruoff, III, M.D., Chairman

Reference Committee "C" met on Sunday, May 15, 1966, with all members present: Doctors Frederick W. Durham, Elbert H. Pogue, Dorsett L. Spurgeon, Sherman Garrison, and the chairman. Approximately 70 delegates and members were present to discuss the various items under consideration. There was considerable lively discussion and many members present clearly presented their individual thoughts on the items considered. Doctor Alfano and Messrs. Skelley and Jones (Vice-Presidents of Blue Cross) were present and aided in the clarification of various points discussed.

1. **Board of Trustees – Items**

A. **Payment of Interns and Residents** (page 294)

The committee *recommends* approval of this report as printed.

Adopted

B. **MSP Non-Assignment Policy** (page 295)

The committee *recommends* approval of this report as printed.

Adopted

C. **MSP Contract Inequities** (page 293)

There was a prolonged discussion with many members participating. The committee expresses its disappointment with the present ruling of the Commissioner of Banking and Insurance, and feels that there is still an area in which third party claims and liability claims could be handled in a more equitable manner. The committee feels that it would be highly desirable that future efforts be made to improve this situation.

The committee *recommends* approval of this report as printed.

Adopted

D. **MSP Board of Trustees** – Nominations (page 293)

The committee *recommends* approval of this report as printed.

Adopted

E. **AID Program (Blue Cross-Blue Shield)** (page 295)

This item was discussed pro and con by several members. The committee feels that the overall benefits which may accrue from this program justify a further year's trial, particularly in view of the rapid development of utilization review committees throughout the state.

The committee *recommends* approval of this recommendation of the Board of Trustees.

Adopted

F. **Discontinuance of AID Program** – Resolution #4 (page 359)

This resolution was discussed along with the recommendation of the Board of Trustees on the AID Program. In view of the recommendation of the committee to approve the Board of Trustees' position, the committee *recommends disapproval* of Resolution #4. (With the future development of utilization review committees, this may become academic.)

Adopted

2. **Medical-Surgical Plan of New Jersey** (page 345), and Supplemental Report (page 354)

The committee *recommends* approval of this report as printed.

Adopted

Armed Forces Dependents' Medical Care Program (page 350)

The committee *recommends* approval of this report as printed.

Adopted

3. **Separation of Professional Fees and Hospital Charges** – Resolution #15 (page 368)

This resolution was discussed in detail, and there was considerable interest in some of the wording of the resolution which was difficult to understand. The committee agrees with the intent of the resolution, and it *recommends* that the present wording be accepted as a basis for the start of negotiations with this proviso. The committee *recommends* approval of this resolution.

Adopted

Report adopted as a whole

Reference Committee "D"

David Eckstein, M.D., Chairman

Reference Committee "D" met on Sunday, May 15, 1966, with all members present: Doctors Raymond A. Taylor, John J. Torppey, Roy A. Morrow, Donald T. Akey, and the chairman. Approximately 15 delegates and members were present to discuss the various items under consideration.

1. **Medical Defense and Insurance** (page 311)

The committee heard detailed reports on Medical Defense and Insurance and availed themselves of the special information available from the insurance carriers. The committee is confident that the best interests of MSNJ are being served under the capable leadership of Dr. Daniel F. Featherston, and wishes to compliment Dr. Featherston and his committee for the remarkably fine work they have done.

The committee *recommends* approval of this report as printed, and further *recommends* that the American Mutual Liability Insurance Company and the E. & W. Blanksteen Agency be continued as carriers for their respective insurance programs.

Adopted

2. **Medical Education** (page 314)

The report of the Committee on Medical Education was discussed. It was the unanimous opinion of the committee that the membership should be informed of the proceedings of such conferences as the Governor's Conference on Education, and further *recommends* that the liaison of MSNJ with the various colleges and professional groups be stated explicitly in future committee reports.

The committee *recommends* approval of this report.

Adopted

3. **Medicine and Religion** (page 343)

The committee read with interest the report of this worthwhile area of endeavor and was glad to hear from the floor that considerable activity on a county level was already a matter of record.

The committee *recommends* approval of this report as printed.

Adopted

4. **Retirement Plan for Physicians** (page 344)

The committee read with interest the report of the Committee on Retirement Plan for Physicians. It was the opinion of the committee and delegates present that the Committee on Retirement Plan for Physicians might well address itself to promotion of this plan to the membership at large. This would necessitate increased activity, with the objective of educating the physician-membership to the importance of this retirement planning.

The committee *recommends* approval of this report as printed.

Adopted

Report adopted as a whole

Reference Committee "E"

Edward A. Schauer, M.D., Chairman

Reference Committee "E" met on Sunday, May 15, 1966, in the West Room, Tower Floor, with all members present: Doctors Frank B. Vanderbeek, C. Spencer Davison, Thomas H. McGlade, Joseph R. Burns, and the chairman. Approximately 20 delegates and members were present to discuss various items under consideration.

1. **Board of Trustees** — Items

The committee considered those portions of the report of the Board of Trustees referred to it. These included the **Community Mental Health Centers** (page 295), **National AMA Programs** (page 295), **JEMPAC** (page 296), and **Animal (Medical) Research** (page 299).

The feeling of the committee after some discussion with reference to JEMPAC was that although there should be continued disassociation between JEMPAC and MSNJ, perhaps there shoul dbe more emphasis on individual physician participation in JEMPAC.

The committee *recommends* approval of all four of these items.

Adopted

2. **Council on Legislation** (page 322) and **Supplemental Report** (page 326)

The committee then considered the report of the Council on Legislation, plus the supplemental report. The committee would like to commend Dr. McCall and the members of the Council on Legislation for their continued excellent work in this field. Particular praise should be given for their perseverance with reference to the amendment to the Medical Practice Act.

The committee *recommends* approval of the reports of the Council on Legislation.

Adopted

3. **Council on Public Relations** (page 339)

The committee reviewed the report of the Council on Public Relations. The committee noted two errors in the report: one appearing on page 72 of the printed reports, second paragraph, wherein the report states "and (2) such education as may be achieved with members of the profession." It would appear that the two words "the profession" in this sentence should be "the public." The second error appeared on page 73, first paragraph, and involved the spelling of the word "Methadon."

With reference to **Emergency Coverage**, it was noted that the Attorney General now has in his possession the Emergency Coverage Plan for each county medical society.

With reference to **Drug Addition**, the committee was pleased to note that the council did at least consider that the interpretation of the Harrison Narcotics Act should be evaluated, although it did not feel at this time that it had sufficient knowledge or authorization to take action.

The committee *recommends* the approval of the report of the Council on Public Relations in its entirety.

Adopted

Report adopted as a whole

Reference Committee "F"

Robert E. Verdon, M.D., Chairman

Reference Committee "F" met on Sunday, May 15, 1966, with all members present: Doctors Rudolph T. DePersia, Charles Cunningham, Lloyd A. Hamilton, Walter E. Corrigan, and the chairman. Approximately 58 delegates and members attended to discuss the various items under consideration.

1. **Board of Trustees — Items**

The committee considered the following four items from the report of the Board of Trustees:

a. Medicare Law (page 296)
b. Health Care of the Aged (page 296)
c. Hospital Based Specialists (page 297)
d. Health Facilities Planning Council (page 297)

The committee *recommends* acceptance of these items as published.

Adopted

2. **Medical Services** (page 329)

The committee notes the increased responsibilities and duties assigned to the Council and commends them for their efforts and for the steps thus far taken in order to deal with the Medicare Law. The committee calls particular attention to the importance of the recommendation of the Council "that utilization review committees be established in each county and that the names of the chairmen and other personnel be sent to this Council."

The committee *recommends* the implementation of this recommendation without delay.

Adopted

3. **Occupational Health, Rehabilitation, Workmen's Compensation** (page 331)

The committee *recommends* the approval of the report as published.

Adopted

4. **Chronically Ill and the Aging** (page 331)

The committee *recommends* that this report be accepted as published.

Adopted

5. **Resolution:**

A. **Compensation of Physicians for Care of Subsidized Patients** — Resolution #5 (page 360)

B. **Compensation of Physicians Under Federal Tax-Supported Programs** — Resolution #6 (page 361)

C. **Compensation of Physicians for Care of Subsidized Patients in Hospitals** — Resolution #12 (page 366)

D. **Compensation of Physicians for Care of all Patients** — Resolution #18 (page 371)

Resolutions #5, #6, #12, and #18 are similar in intent and were therefore considered together. The committee offers the following substitute resolution, to cover the intent of all four resolutions:

Whereas, for generations medical services have been rendered to the indigent by members of the medical profession without thought of recompense and have been taken for granted by the community at large; and

Whereas, changing socio-economic philosophies and practices have resulted in the government's assumption of fiscal responsibility for indigent patients; and

Whereas, in common with all other citizens, physicians are being heavily taxed to support the government in this role; and

Whereas, government compensates all other suppliers of services for which it assumes financial responsibility; and

Whereas, the Supreme Court of New Jersey has recently made formal declaration of a newly adopted policy urging the compensation by government of all attorneys who render professional services to clients unable to meet such costs themselves; and

Whereas, it is unjust, unreasonable, and discriminatory to expect that only members of the medical profession should render free services to patients who are wards of government and therefore eligible for full subsidization; and

Foregoing paragraph amended to read:

Whereas, it is unjust, unreasonable, and discriminatory to expect that only members of the medical profession should render free services to patients who are beneficiaries of government subsidies; and

Whereas, such patients, having the resources of government at their disposal, can no longer claim service in charity as their due; and

Whereas, nowhere does the Hippocratic Oath, medical ethics, medical training, or medical licensure require that members of the medical profession render services free to patients who are able to pay, as wards of government certainly are; and

Foregoing paragraph amended to read:

Whereas, nowhere does the Hippocratic Oath, medical ethics, medical training, or medical licensure require that members of the medical profession render services free to patients who are able to pay, as beneficiaries of government subsidies certainly are; and

Whereas, precedents have already been set in Michigan and Oklahoma, where the medical societies have, through negotiation, prevailed upon the civil authorities to provide fee-for-service compensation for services rendered to patients in this category; now therefore be it

RESOLVED, that professional services rendered to patients whose health care costs are the responsibility of governmental or other agencies should be billed by physicians on their usual and customary fee-for-service basis; and be it further

RESOLVED, that MSNJ make public declaration of this policy by July 1966 and take whatever steps are necessary to effectuate it.

Your committee *recommends* the adoption of this substitute resolution and, in consequence thereof, it *recommends* that #5, #6, #12, and #18 be not adopted.

Adopted as amended

E. **The Ethics of Individual Responsibility** — Resolution #16 (page 369)

F. **Individual Responsibility Program**—Resolution #19 (page 372)

The committee considered Resolution #16 and #19 to be so closely related as to be identical for practical purposes. However, the committee unanimously concluded that Resolution #16 more concisely and clearly stated the purpose and intent of both resolutions. It therefore directed its attention to Resolution #16. The committee *recommends* that the fourth "whereas" be deleted and that this Resolution as amended by that deletion be adopted.

The committee *recommends* the adoption of Resolution #16, as amended above.

Rejected.

In view of its approval of Resolution #16, the committee agreed that Resolution #19 is superfluous and *recommends* that it be not adopted.

In consequence of the position and action of the House concerning Resolution #16, the chairman of the reference committee recommended that Resolution #19 be not approved.

Adopted

G. **Expansion of Medical School Facilities** — Resolution #17 (page 370)

The committee suggests that the first "resolved" in this resolution be amended for clarity, as follows:

RESOLVED, that New Jersey medical schools receiving tax monies be urged to expand their enrollments; and be it further

RESOLVED, that a third medical school be planned for New Jersey; and be it further

The concluding "resolved" of the resolution would remain as published.

The committee *recommends* adoption of this resolution, as amended.

Adopted

H. Urging the Creation in New Jersey of Top-Level Health Care Planning and Administrative Groups for the State as a Whole and For its Various Subdivided Health "Regions" — Resolution #20 (page 373)

The committee *recommends* the adoption of this resolution.

Adopted

I. Urging the Passage of Implementing Legislation for Title XIX — Resolution #21 (page 374)

The committee suggests amendment of this resolution by the addition of a third "resolved," as follows:

RESOLVED, that MSNJ strongly recommend the selection of Blue Shield and Blue Cross as fiscal intermediaries or administrators.

The committee *recommends* adoption of this resolution, as amended.

Adopted

Report as a whole adopted as amended

Reference Committee "G"

John J. Thompson, M.D., Chairman

Reference Committee "G" met on Sunday, May 15, 1966, with all members present: Doctors Francis J. Benz, Theodore K. Graham, Charles W. Boozan, Edward L. Minier, and the chairman. The committee wishes to thank Doctor Joseph R. Jehl, our newly elected President, and Doctor Louis K. Collins, our newly elected President-Elect, for their helpful participation in the discussion of reports. Approximately 15 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees** — Items

A. **Air Pollution Control** (page 297)

The committee discussed and accepted the report of the Board of Trustees concerning the Committee on Air Pollution Control and *recommends* the report for approval.

Adopted

B. **Mental Health Committee Structure** (page 297)

This item was discussed and recommendation will be made under the report of the Committee on Mental Health.

C. **Heart Disease, Cancer, and Stroke** (page 297)

The committee discussed and accepted the report of the Board of Trustees concerning their cooperation with, and their action in supporting, the President's Commission on Heart Disease, Cancer, and Stroke.

The reference committee *recommends* approval of this report.

Adopted

2. **Public Health** (page 332)

The committee discussed and accepted the portion of the report from the Council on Public Health about Mental Health Committee Structure, and *recommends* its approval with the amendment as noted under the report of the Committee on Mental Health.

Adopted

The committee discussed and accepted the remainder of the report of the Council on Public Health.

The committee *recommends* approval of this report.

Adopted

3. **Air Pollution Control** (page 333)

The committee discussed and accepted the report of the Committee on Air Pollution Control and *recommends* the report for approval.

Adopted

4. **Cancer Control** (page 334)

The committee *recommends* approval of the report of the Committee on Cancer Control and their recommendation; namely, "that physicians and surgeons on hospital staffs encourage and utilize the hospital cancer programs, so that more programs will meet the standards of the American College of Surgeons."

The committee moves for approval of this portion of the report.

Adopted

5. **Child Health** (page 335)

The committee *recommends* approval of this report.

Adopted

6. **Conservation of Hearing and Speech** (page 337)

The committee *recommends* for approval the chairman's explanation of no meetings for his committee.

Adopted

7. **Conservation of Vision** (page 337)

The committee *recommends* approval of this report as printed.

Adopted

8. **Maternal and Infant Welfare** (page 338)

The committee *recommends* approval of this report as printed.

Adopted

9. **Mental Health** (page 338)

The committee discussed and accepted the report of the Committee on Mental Health and *recommends* its approval.

Adopted

The committee read and discussed the recommendation from the Committee on Mental Health for the change in committee structure for Mental Health. Their recommendation reads: "that the Special Committee on Mental Health be elevated to the status of an administrative council with special committees, as necessary, to deal with alcoholism, drug addiction, mental retardation, mental illness of children and adolescents, epilepsy, neurological disorders, and psychiatric disorders *of the aged.*

The reference committee *recommends* an amendment to this recommendation; namely, deleting the last three underlined words *"of the aged"* and to end this sentence with a period after "disorders."

The amendment now reads: "that the Special Committee on Mental Health be elevated to the status of an administrative council with

special committees, as necessary, to deal with alcoholism, drug addiction, mental retardation, mental illness of children and adolescents, epilepsy, neurological disorders, and psychiatric disorders."

The committee *recommends* this amendment be approved.

The committee *recommends* approval of this portion of the report as amended.

Adopted

10. **Resolutions**

A. **Establishment of Special Committee on Alcoholism** — Resolution #7 (page 362)

In connection with the resolution from the Bergen County Medical Society — namely "Establishment of Special Committee on Alcoholism" — no action was taken in the interest of not being redundant. The intent of this resolution of Bergen County has been included in the previously approved proposal for the change in structure of the Committee on Mental Health, by elevating it to an administrative council which will establish, among other committees, one on alcoholism.

Adopted

B. **Desirability of Use of Safety Lenses in Children** — Resolution #8 (page 363)

The committee read and discussed the resolution from the Burlington County Medical Society entitled "Desirability of Use of Safety Lenses in Children" and approved the resolution.

The committee *recommends* this resolution be approved; and the committee further *recommends* that the resolution be sent to the Committee on the Conservation of Vision for study and implementation.

Adopted

Report adopted as a whole

Reference Committee "H"

Conrad M. Bahnson, M.D., Chairman

Reference Committee "H" met on Sunday, May 15, 1966, with the following members present: Doctors George T. Hare, John P. Coughlin, Walter R. Edwards, and the chairman. Approximately 20 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees** — Items

Bicentennial History (page 298)

The report of this committee was reviewed and approval of this report is *recommended* including the committee's following comments:

The reasons for delay in publication were given at a meeting of the House of Delegates yesterday. The committee looks forward to its publication date, because of the very conscientious and capable author, Dr. Fred B. Rogers.

Adopted

2. **Annual Meeting** (page 305)

The report of this committee was reviewed. Approval of this report is *recommended,* including the committee's following comments:

Suggestion is made that the Annual Meeting Committee try to get a less conflicting scheduling for the 1970 convention by such means as having the time of the meeting advanced; and, furthermore, that the Annual Meeting Committee investigate the apparent shortage of hotel staff to handle the heavy traffic of incoming and outgoing guests.

Adopted

3. **Scientific Exhibits** (page 307)

The committee *recommends* approval of this report as printed.

Adopted

4. **Scientific Program** (page 306)

The committee *recommends* approval of this report as printed.

Adopted

5. **Disaster Medical Care** (page 343)

The committee *recommends* approval of this report as printed.

Adopted

6. **Honorary Membership** (page 310)

The committee *recommends* approval of this report as printed.

Adopted

7. **Nursing Education and Recruitment** (page 344)

The report of this committee was reviewed, and approval of this report is *recommended,* including the committee's following comments:

The committee should make overtures to the Hospital Administrators' Association or the Hospital Association of the state to encourage increased nursing training facilities and standardization to ease the burden on hospitals maintaining nursing training schools, as compared with hospitals which maintain no nursing training schools.

Adopted

8. **Traffic Safety** (page 344)

The committee *recommends* approval of this report as printed.

Adopted

9. **Woman's Auxiliary Advisory** (page 319)

The committee *recommends* approval of this report as printed.

Adopted

10. **Nominations for Emeritus Membership** (page 356)

Including those on the supplemental report, the nominations were reviewed. The reference committee *recommends* approval of all nominations submitted.

Adopted

11. **Resolution**

A. **Meeting Schedule of House of Delegates** — Resolution #9 (page 363)

This resolution urged that the House of Delegates return to a schedule of meetings on Saturday, Sunday, and Monday, as was the custom for many years.

After hearing discussion by representatives from several counties, your committee agreed that the resolution should be *disapproved* and so *recommends.*

Adopted

Report adopted as a whole

Reference Committee on Constitution and Bylaws

Josiah C. McCracken, Jr., M.D., Chairman

The Reference Committee on Constitution and Bylaws met on Sunday, May 15, 1966, with all members present: Doctors John L. Olpp, Edward Foord, Robert E. Jennings, Anthony L. Rifici, and the chairman. Approximately 18 delegates and members were present to discuss the various items under consideration.

1. Committee on Revision of Constitution and Bylaws

A. **Amendment to Bylaws** (page 320)

The recommended revision of the Constitution and Bylaws as proposed concerning Chapter V — Procedure of Election — as presented to the first meeting of the House of Delegates — was read and discussed by the committee and members attending the Reference Committee on Constitution and Bylaws. Such discussion included remarks concerning proper representation of individual counties and the proposed changing of representation of individual counties according to size. The discussion included remarks for and against such a change. The proponents of a change agreed that further study of the problem was justified.

The reference committee *recommends* that the subject be referred to the Board of Trustees for further study by a committee which would include members of the permanent Committee on the Revision of the Constitution and Bylaws. The members of this committee realized the depth of this problem, but believe that the conclusions of the study can be completed and recommendations be made at the next meeting of the House of Delegates at the 1967 Annual Meeting.

Adopted

B. **County Judicial Committees** (page 321)

After careful review and consideration, the committee concurred with the standing committee that no action is necessary because it was clearly stated by members of the Board of Trustees and Legal Counsel that the present insurance carrier and any future insurance carrier does, and will, cover any member of county committees and officials of county associations. Therefore, modification of the Bylaws is not necessary to accomplish what the proponents of the resolution desired. Therefore, the committee *recommends* that no such amendment be undertaken.

Adopted

The chairman at this time wishes to thank the members of his committee, and all other members and delegates who participated in the meeting.

Report adopted as a whole

1967 MSNJ ANNUAL MEETING

May 13-14-15-16-17, 1967 Haddon Hall, Atlantic City

Report of Nominating Committee and Election

Charles H. Calvin, M.D., Chairman

May 15, 1966

OFFICE	TERM	FROM TO	NOMINEE and COUNTY
President-Elect	1 year	May 1966–May 1967	Louis K. Collins, Gloucester
1st Vice-President	1 year	May 1966–May 1967	John F. Kustrup, Mercer
2nd Vice-President	1 year	May 1966–May 1967	Nicholas A. Bertha, Morris
Secretary	1 year	May 1966–May 1967	Marcus H. Greifinger, Essex
Treasurer	1 year	May 1966–May 1967	Daniel F. Featherston, Monmouth
Trustees:			
2nd District	3 years	May 1966–May 1969	Matthew E. Boylan, Hudson
3rd District	3 years	May 1966–May 1969	George E. Barbour, Somerset
3rd District	3 years	May 1966–May 1969	Samuel J. Lloyd, Mercer
4th District	3 years	May 1966–May 1969	Frank J. Hughes, Camden
11th Trustee	3 years	May 1966–May 1969	Andrew C. Ruoff, Morris
Judicial Councilors:			
1st District	3 years	May 1966–May 1969	Thomas S. P. Fitch, Union
4th District	3 years	May 1966–May 1969	E. Vernon Davis, Burlington
AMA Delegates:			
	2 years	Jan 1967–Dec 1968	C. Byron Blaisdell, Monmouth
	2 years	Jan 1967–Dec 1968	Marcus H. Greifinger, Essex
	2 years	Jan 1967–Dec 1968	Frank J. Hughes, Camden
	2 years	Jan 1967–Dec 1968	Luke A. Mulligan, Bergen
AMA Alternate Delegates:			
	2 years	Jan 1967–Dec 1968	F. Clyde Bowers, Morris
	2 years	Jan 1967–Dec 1968	Matthew E. Boylan, Hudson
	2 years	Jan 1967–Dec 1968	Jerome G. Kaufman, Essex
	2 years	Jan 1967–Dec 1968	John F. Kustrup, Mercer
Delegates and Alternate Delegates to Other States:			
New York:			
Delegate	1 year	May 1966–May 1967	Joseph P. Donnelly, Hudson
Alternate	1 year	May 1966–May 1967	David B. Scanlan, Atlantic
Connecticut:			
Delegate	1 year	May 1966–May 1967	Lloyd A. Hamilton, Hunterdon
Alternate	1 year	May 1966–May 1967	Frank W. Konzelmann, Atlantic
Administrative Councils:			
Legislation:			
5th District	3 years	May 1966–May 1969	John S. Madara, Salem
6th Member	3 years	May 1966–May 1969	Winton H. Johnson, Bergen
Medical Services:			
5th District	3 years	May 1966–May 1969	Charles B. Norton, Jr., Salem
6th Member	3 years	May 1966–May 1969	I. Edward Ornaf, Camden
Public Health:			
5th District	3 years	May 1966–May 1969	Carl J. Records, Cape May
6th Member	3 years	May 1966–May 1969	John P. Coughlin, Hudson
Public Relations:			
2nd District	3 years	May 1966–May 1969	Francis I. Tomlins, Bergen
5th District	3 years	May 1966–May 1969	Josiah C. McCracken, Atlantic
Standing Committees:			
Annual Meeting	3 years	May 1966–May 1969	Robert E. Verdon, Bergen
Finance and Budget	3 years	May 1966–May 1969	Theodore K. Graham, Passaic
Medical Defence and Insurance	3 years	May 1966–May 1969	Ernest C. Hillman, Jr., Essex
Medical Education	3 years	May 1966–May 1969	Louis F. Albright, Monmouth
Publication	3 years	May 1966–May 1969	George B. Sharbaugh, Mercer
Woman's Auxiliary Advisory	3 years	May 1966–May 1969	George O. Rowohlt, Bergen

All nominees were elected to the designated offices for the terms indicated

GENERAL SESSION

Sunday Afternoon, May 15, 1966

The General Session on Medicare convened at 3:45 p.m. Ernest B. Howard, M.D., Assistant Executive Vice-President of the American Medical Association, presided. Three panelists discussed *"What You Should Know About Medicare"* as indicated:

From the Viewpoint of the Social Security Administration . . . ARTHUR E. HESS, Director, Bureau of Health Insurance, Social Security Administration, Department of Health, Education, and Welfare, Baltimore, Md.

From the Viewpoint of the Public Health Service . . . JOHN W. CASHMAN, M.D., Chief, Division of Medical Care Administration, Public Health Service, U. S. Department of Health, Education, and Welfare, Washington, D. C.

From the Viewpoint of The Carrier (P. L. 89-97) . . . WILLIAM C. WHITE, Jr., The Prudenital Insurance Co. of America, Newark, N. J.

The President: Our guests, ladies and gentlemen:

At the 18th Annual National Business Conference held two weeks ago, George Champion, President of the Chase Manhattan Bank, said: "Private business should wage an all-out campaign of cooperative competition with Government in developing an imaginative new approach to economic and social problems. Nothing would put the brakes on Government faster than for business to identify critical problems and take the initiative in dealing with them before Washington felt the need to act." On the same day, a man named Johnson, President of the Royal Globe Indemnity Insurance Companies, said: "The insurance business is in partnership with Uncle Sam, and if it doesn't make a go of it, Uncle Sam will become the principal partner." In short, business is fighting for survival.

He further stated that business must abandon its custom of defending the *status quo* and anticipate sociological change with affirmative action.

With the advent of Medicare, I think American Medicine finds itself in a similar position. With the rumblings both from the White House and Congress about lowering the age limits and expanding the benefits of the Medicare Act, and with Title 19 posing to many a bigger threat to the practice of medicine as we know it than Medicare itself, your Society has enlisted this distinguished panel to shed light on this problem.

The panel consists of Arthur E. Hess, Director of Health Insurance of the Social Security Administration, United States Department of Health, Education and Welfare; John W. Cashman, M.D., Chief of the Division of Medical Care Administration in the Public Health Service, United States Department of Health, Education and Welfare; William C. White, Jr., of the Prudential Insurance Company of America; and our own Dr. Ernest B. Howard, Assistant Executive Vice-President of the American Medical Association.

At this point I turn the meeting over to Dr. Howard, who will act as Moderator. Thank you. (Applause)

Dr. Ernest B. Howard: Thank you, Dr. Bedrick.

Ladies and gentlemen: We have a splendid panel, who I know will bring you up to date on what is happening in the Medicare area. Many conversations are now going on concerning some of the sticky areas of Title 18, and many of the questions will be resolved before July 1, but are not yet totally resolved.

Mr. Hess is Director of the Bureau of Health Insurance. He is a graduate of Princeton, a native of Pennsylvania, and has been a pleasure to work with for many years; as a matter of fact, he was Director of the Bureau of Disability Insurance before he assumed his new post, and AMA and all the doctors who worked with him were very happy in that total relationship.

I'm very happy to introduce you, Art, to the audience. (Applause)

Mr. Hess: In the 20 decades that have passed since 1766 when your society was founded, there have been many dramatic and significant advances in the diagnosis, treatment, and prevention of diseases. When The Medical Society of New Jersey first put on its swaddling clothes two centuries ago, ether and chloroform were undreamed of. Pasteur had not even been born. Since that day, the hospital and nursing home have replaced the "pest houses" and "poor farms" where those suffering from contagious diseases and the infirmities of old age were more often than not relegated. Today things are far different, in every facet of health care.

This year we are on the threshold of a dramatic development in the financing of health care. Beginning July 1, for the first time, virtually all Americans 65 and over, an entire class of citizens, will receive necessary hospital and related services as insured patients and, the great majority — approximately 17 million out of the total of 19 million — will have protection against the costs of physicians' services and many medical services not covered by the basic hospital insurance plan.

We are too close to the beginning to judge — and, indeed, we may not yet agree on all that this may mean. But none of us can deny that we need to work together to assure that the effects of these new programs are positive, that everything that has been achieved in medical care will be preserved under Medicare, and that some of what has not yet been achieved (though the goals had previously been professionally established) will be hastened in its achievement by the new financing of health services which Medicare will provide. I can assure you that in the administration of Medicare, we are conscious of the responsibility we have toward the health community and toward medicine. It is that community and you, the physicians, who have always — and will always — set the professional goals for health care.

I think it is fair to say that many of us in the long years of debate which preceded enactment of Medicare may have become stereotyped in our positions. Some of the vocabulary of the debate still persists — but, in an ever lessening degree, as we have gone about the task of implementing the law within the guidelines set by Congress. In this task we have received generous and invaluable assistance and advice from representatives of national organizations, as well as individual physicians who have labored with us as members of our various technical work groups. The members of these committees have been active and articulate in expressing their viewpoint and sharing their knowledge with us — and I might add, earning our respect in the process. We have also had the immensely valuable advice and assistance of a hard-working Health Insurance Benefits Advisory Council, which numbers 9 physicians among its 16 members. The contributions of these many people — who generally also are highly representative of the viewpoints of their state and local medical societies — are far too extensive ever to record in detail.

We have now reached the stage, however, where it is important to begin making a transition from policy making at the national level to program implementation and performance evaluation at the state and local levels of medicine. We need the help of your Society and the benefit of your experience in this process. We hope to create an operating climate that will assure every physician the opportunity, if he wishes, to bring his professional judgments to bear — either individually, or as a member of his local and state medical society — to assist in working out the manner in which the program is administered in his area. We believe that the carriers and fiscal intermediaries—local organizations with experience and expertise in reimbursement and health community relationships — will afford the kind of focus for your participation that will help to bring program objectives and your professional objectives into harmony. All of our regional, state, and local operating components are being encouraged to confer with individual physicians and professional organizations in their localities, and to develop close and continuing working relations, particularly with medical societies.

Let me assure you we will welcome at all times your static and your feedback to our operating components on the problems and needs of the physician and of the patient. We are committed to continue the consultation which has been so successful in our initial working relations with the medical profession and other professional groups at the national level — but this consultation must now be extended to the state and local community level. The program can be formulated at the national level — but it functions at the local level. That is where the 19 million beneficiaries are, and that is where the health community that delivers services is.

Your program has labeled the topic for this session "What You Should Know About Medicare," and I do not interpret my mission, however, as reciting to you the program's provisions or interpreting the content of regulations that are now being worked on. We will, within a few weeks, distribute to all physicians in this country the *Reference Guide to Health Insurance to Social Security,* which will have many of the "bread-and-butter" details that you will want to know about the benefits of the program and the methods of operation. Moreover, we will also issue another handbook to all of the 19 million beneficiaries, telling them what they need to know — and we will give you copies of this, too. Then, finally, the most detailed and continuing help that you will get will be from the insurance carrier designated in your state to handle claims for medical insurance. I view my appearance in the limited time this morning, therefore, as an opportunity to give you the broad philosophy and approach that will show you the general climate in which we intend this program to operate.

There are several facets of the program that I wish to discuss with you in detail, such as utilization review, the reimbursement of physicians' charges, certification and recertification, and the enlargement of the variety of health services which can be recommended for the treatment of your aged patients in the light of their insured status as health insurance beneficiaries.

But first, let me point out a keystone of the Medicare structure: the law specifically prohibits any administrative exercise of supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration and operation of medical facilities. You may say that these were easy words to write and that you will reserve judgment. That is a fair position to take — the burden is clearly on us to prove that our common objectives can be achieved within this policy framework. But, let me assure you, we *will* prove it — and I think we will prove it by working together. We do not live in different societies. You practice medicine and we administer laws. But we both value the kind of freedom these prohibitions protect.

Turning now to utilization review. . . . As you know, an accredited hospital, or a nonaccredited one that meets equivalent standards, can qualify for participation if it establishes a utilization review plan. The utilization review plan will help to assure that hospital services will not be excessively or inappropriately utilized for inpatient services furnished by a hospital to patients entitled to benefits under Medicare. The principles of utilization review are not the brain child of the Social Security Administration or of the Congress which directed that they be applied. These principles had been developed by the medical profession itself — not as a policing mechanism, but rather as an educational apparatus to further the important institutional and professional objective of proper utilization of facilities.

The key to our policy will be: The operation of the utilization review plan is the responsibility of the organized medical staff of the hospital. Establishing the plan and applying it rests with the administrative and medical staff, with wide latitude for the exercise of local option. We look to the professional members of these committees to apply professional criteria to the cases under review. Some physicians are concerned that the utilization review requirements usurp the physician's responsibility for the medical management of

his own patient. This is a misapprehension. It will have a heavy statistical orientation, and it will operate in the context of the activities of the organized medical staff, or its equivalent. Utilization review is not — and I emphasize NOT — an administrative review of professional practices; rather it is a *professional review* of professional practices.

Where an institutionally-based committee is beyond the staff capacity of a small institution, the utilization review may be conducted by an outside group developed with the assistance of a local medical society. Your active help in this area to the fiscal intermediaries and to hospitals may in some instances make the difference in the availability or non-availability of qualified services to beneficiaries. Your attention is further called to the fact that extended care facilities, sometimes referred to as skilled nursing homes, also are required to have utilization review plans. By the very nature of their staffing arrangements, it will be necessary, in most instances, to establish an outside group to perform this highly important function. Here again, the assistance of the medical societies should help to work out imaginative and professionally valid approaches to the problem of utilization review.

As in many public and private programs paying for health care, physician certification (and recertification in long-term cases) is required as a condition of payment for services under hospital insurance. No certification, however, is needed for physicians' services. And, in respect to non-institutional services, the physician's prescription or order will usually be sufficient. The main impact will be in the area of institutional services. Here, the method by which the required certification is accomplished will, within certain broad guidelines, be left to the judgment of the medical and administrative staff of the individual institution with the assistance, if need be, of the fiscal intermediary. And, I might add, we will not require the submittal to the intermediary of special forms. In the main, the certification will be part of the patient's institutional records, and remain there. Ordinarily, the physician will include the certification on a form he would regularly sign as part of the institutional records of patient care.

We will shortly announce recertification policies which have been under extensive consideration. In general, we will ask for recertification at intervals that are based on the particular characteristics of different kinds of care. For example, we will want recertification for inpatient hospital care more frequently than for home health services, because we are there at an earlier level of care which presents alternatives that need to be regularly reviewed for appropriateness.

And, what does all this mean in terms of your active participation and assistance? It means three things, all of them of prime importance. First, I would hope that you see fit to participate, if the occasion arises, as individuals by serving on utilization review committees with a sense of professional concern and not with a feeling of administrative mandate. Second, I urge you to work as a society in setting a salubrious climate for the acceptance of the utilization review function, just as you have given support to other measures of professional self-review. Finally, it is possible for you to help small hospitals and extended care facilities with limited staffs in working out utilization review technics on a community basis or through the help of the fiscal intermediaries that serve these institutions.

Extended care facilities, as you probably know, are also required to have a "transfer agreement" with at least one participating hospital. Your advice and counsel to institutional administrators and boards will certainly be needed in order to develop appropriate agreements that are consistent with the purposes of the program and are effective in serving the principle of continuity of care.

We also need your active assistance in explaining to other physicians, aged people, and their children the "prior-hospitalization requirement" for extended care facility benefits. Physicians can be of great service to the program if they help us get across the fact that the prior hospitalization requirement is not just a

gimmick to be met in order to have payment made for extended care services. The actuarial soundness of the health insurance program will in part depend on proper administrative attention to this provision.

The prior hospitalization requirement means that before the beneficiary can receive post-hospital extended care services or post-hospital home health services, he must have been an inpatient of a hospital for at least 3 consecutive days. The purpose of this requirement is to assure that post-hospital benefits are limited to those individuals who required hospitalization initially, but who could later be transferred to levels of less intensive and less costly care.

The 3-day requirement also helps to assure that there is a full appraisal of the medical condition and needs of the patient before he is transferred from the hospital to post-hospital care. It must be emphasized that the intention of the law does not mean individuals are to be hospitalized when this is not medically necessary, simply to fufill the 3-day transfer requirement.

I would like to give further emphasis to home health services as an area in which medical societies can render invaluable assistance not only to the program, but also to the communities in which they are located. Home health visits by nurses and special therapists are provided under both the hospital and medical insurance parts of Medicare. But in each instance — and there is no exception — the services may be reimbursed only if they are provided by a home health agency (including, of course, a hospital with a home-care program) under a plan developed, and periodically reviewed, by a physician. This means we must be assured that the services grow out of medical necessity and are part of a medically supervised therapeutic program representing a home-based level of care as an alternative to more costly institutional care. I suspect that many, if not all, of you will agree that home-based care has great medical significance for elderly people not only in conserving expensive institutional resources, but for many of them, the psychological advantages of being at home with their families and in familiar surroundings is an element of positive therapeutic value.

All of this is very true, I can almost hear some of you commenting, but just where does the local medical society come into this picture? I concede the connection may be obscure. But you are aware, I know, that in community after community, home health service and all that it entails in continuity and availability of health care is inadequate or completely lacking. With the advent of Medicare and the expansion of reimbursement for the cost of providing the best care the health community has to offer, leadership at the state and county medical society level is needed as well as from the hospital and nursing fields, to assure development and expansion of organized home care and visiting nurse programs.

Before closing, I want to direct my remarks to the day-by-day operational aspects of the Medicare program. As you now know well, the local administration of the program will be in the hands of intermediaries presently engaged in health insurance and prepayment activities — organizations with well-established relationships with the health care community. Under the hospital insurance part of the program, fiscal intermediaries have been selected from among organizations nominated by groups or associations of providers.

The functions of these intermediaries will be primarily to pay for the cost of services rendered to beneficiaries by hospitals, extended care facilities, and home health agencies, and to give assurances, through sound claims administration, that proper payments are made and that effective utilization of facilities and services is accomplished at all levels of care provided Medicare beneficiaries. They will also provide consultative services to hospitals, extended care facilities, and home health agencies in their efforts to improve accounting, recordkeeping, cost finding technics, and the general quality of health care offered.

We have also selected a variety of private

health insurance carriers to serve as intermediaries under the medical insurance part of the program. Under the term of its contract, each such carrier will work closely with local medical societies to fulfill its responsibility for determining "reasonable charges" for covered services rendered to Medicare beneficiaries by physicians.

Let me comment briefly on this matter of "reasonable charges." Medical insurance carriers will apply three criteria in determining reasonable charges. First, they must consider the customary charges generally made by the physician for similar services. Second, they must consider the prevailing charges in the locality for similar services. Third, the intermediary may not determine reasonable charges at a level beyond what would be the basis for making payments to physicians on behalf of its own policyholders who receive comparable services under comparable circumstances. The basic concept in the law is to pay each physician equitably in the light of his customary charges to his patients and with due regard to the levels of prevailing charges in the locality. As we interpret this provision, the intermediary may not consider the income of an individual as a factor in determining reasonable charges. An organization selected to serve as an intermediary will be able to make reimbursement on the basis of its existing programs and fee schedules only to the extent that this results in determinations of reasonable charges that are consistent with *all three* criteria set by the law.

We intend to pay, and we will pay, through the third-party intermediaries the full reasonable cost of institutional services under the hospital insurance program. We have just released the principles of cost reimbursement to accomplish this. We intend also to pay the full reasonable charges for physicians' services under the medical insurance part of the program. This will fill in much of the financial gap which previously existed when services were provided on a charitable or part-payment basis. Filling in the financial gap should also help to fill in quality gaps. I must, however, voice a note of concern and caution which I know you will respond to. In committing itself to pay reasonable costs and reasonable charges, we must all be concerned about inflation of the costs of care — not only to this program — but to the community at large. I am sure we will have the cooperation of your Society and of all other components of organized medicine in exercising self-restraint and professional review over the factors that affect equitable charges and economical utilization.

In summary, we are entering the financing of services in the health care field — not as a provider, but as a purchaser — not competitively, but cooperatively — not at discounted rates of reimbursement, but at the level of meeting reasonable costs and reasonable charges — and not with standards which will cause the quality of health care to deteriorate, but with full commitment to the support and elevation of current professionally-approved standards of health care.

I assume our common purposes are, therefore:

1. Maintaining and encouraging quality of care through adequate financial support and with professionally established standards;

2. Conserving program funds and assuring effective utilization of scarce or costly facilities in the community by professional and community-based surveillance of utilization; and

3. Exercising professional restraint and self-control over the cost elements of reasonable costs and reasonable charges by conscientious effort to make costs and charges not only fair and equitable to physicians and institutions but also to consumers and to third-party purchasers generally.

Earlier in my remarks, I pointed to the importance of establishing a meaningful communication between the organized local medical community and those responsible for program administration. The importance of such communication in the partnership which we have entered into cannot be over-emphasized. We hope and, frankly, we expect — and I think you do, too — that this cooperative relationship between social security and organized medicine will be one that we can all be proud of. Thank you. (Applause)

Dr. Howard: The Public Health Service has been assigned some important duties in connection with this war. Dr. Cashman, our next speaker, is Director of the Division of Medical Care Administration in the Public Health Service. He will bring us up to date on what his agency is doing with respect to that problem. Dr. Cashman.

Dr. John W. Cashman: Thinking about the remarks I wanted to bring to you, considering the great degree of sophistication that's present in this audience, I was reminded of the legend about the survivor of the Johnstown Flood. This man lived a great many years after that flood. At a ripe old age he went to meet his Maker. As he entered the portals of Heaven, he was greeted by the Gatekeeper who gave him a sheet of paper, showing where he was to stay and all the things he was to do. And at the end he said, "Well, now, is there anything that I can do for you?"

The old gentleman said, "Well, yes." He said, "You know, I'd sure like it if sometime you can call all the folks together, and I could tell them about the Johnstown Flood."

The Gatekeeper said, "Well, we'll see if this can be arranged."

So, on an appropriate day, the Hosts of Heaven were convened for the purpose of hearing this gentleman. As the Gatekeeper had introduced him to this great host of people, he turned around and said, "Well, now, I've gathered all these people together. They are here to hear your story. But I want you to remember that Noah is in the audience." (Laughter)

That's the way I feel when I address such a fine audience as this.

But let me say that for the health professions in general, and for those in public health work in particular, Medicare is a wonderful opportunity to look at better ways of doing things, here and now. The opportunity is punctuated by the fact that the Secretary of Health, Education, and Welfare has delegated responsibility for the professional health aspects of Medicare to the Public Health Service.

Public Health has long sought the improvement of medical care administration through research demonstrations, and other ways of studying and evaluating the organization, supply, delivery, quality, and financing of health care. The regular activities of the Public Health Service have long included the development and improvement of nursing home, home care, and other out-of-hospital programs through grants to the states, through technical assistance, demonstrations, consultation and training. The advent of Medicare has expanded these activities.

Medicare will improve the quality and, over time, will increase the availability of medical care, and patients of all ages will enjoy these benefits. Dr. William H. Stewart, the Surgeon General, recently stated that the Medicare program "is a door opened wide for us in the health professions to accomplish things we have talked about for years."

"In a sense, this legislation underwrites the development of quality services," he said. "Further, through the utilization review process, the legislation provides a means for assuring that our resources are used with maximum effectiveness in meeting patients' needs." Such is the opportunity as seen by the Surgeon General.

Medicare will make it easier for the physician to provide his aged patients with the kind of care he wants them to have. It already has made home health and nursing home resources more accessible by providing a method of paying for care in them. It will raise the quality of care available in provider institutions through national standards. It will foster local initiative by encouraging the development and improvement of local facilities and services for continued care in the community. The program also has assigned new scope to the role of the state health department. The 3-C role — certification of providers, consultation with them, and coordination of this program with other activities — has involved, and

will involve, both an expansion of the ongoing activities and the conduct of new tasks by state and local health departments. Moreover, the feedback from the state agencies as a result of their activities in the 3-C process will provide valuable information for future program planning.

The impact of Medicare on public health departments will be measured in the impact that health departments will have on the future of medical care in this country. The impact will be gauged in the context of our existing system of medical care and in concert with the other new and existing public programs.

Public health teams across the country will be able to build on the interest that we have in Medicare. This is a program which will strengthen the agencies helping to administer it. The program will increase understanding of, and experimentation in, the administrative process as it relates to medical care. It will increase access to health education. The experience of Medicare will be analyzed by a nine-member National Medical Review Committee, a majority of them physicians, and this continuing study may well lead to changes not only in the way covered care and services are used, but in health care in its broadest definitions.

The Medicare program has already provided valuable experience in interagency cooperation between the Public Health Service and the Social Security Administration, and between practicing physicians and administrative physicians. It has brought together staff with different orientations and experiences, staff from disciplines once considered widely separated, and it has defined the problems and made more significant the success in working together. It is most assuredly blazing new trails in such joint efforts. The same cooperative activities are sure to take place with increasing frequency at all levels.

Medicare is a program that underscores opportunity. It will provide the basis for continuity of care. It will make home health and nursing home resources more accessible by providing a method of paying for care in them.

It will tend to raise the quality of care available to persons of all ages. It will, for example, assure the physician of quality service by the independent laboratory he utilizes to assist his diagnosis. It will assure him of the availability of qualified nursing services for the patient he sends to a nursing home and of the availability of home health services under adequate supervision for the patient requiring home care. It may well be a springboard for physician leadership in planning for the health needs of the community.

With regard to Medicare and existing needs, the key question today is: Are health facilities and manpower sufficient to meet the demands? Are the services available? Can the nation deliver what its 19 million aged people have taken as a promise from this program?

There are certainly trouble spots ahead. Medicare will add strong pressures on general hospitals in many sectors to deliver the types of high quality services which Congress wants and is willing to pay for. Mr. Wilbur Cohen, the Under Secretary of Health, Education, and Welfare, has stated the Nation is short 150,000 hospital beds and over 300,000 nursing home beds. Other estimates have been made that a million more people are needed in health work to augment the nearly three million we now have.

The recent White House Conference on Health identified the most pressing manpower needs: more health professions, more paramedical personnel, and more effective use of existing manpower through education and interplay between professional groups.

It will require a joint mobilization of private and public resources to meet these problems of inadequate facilities and insufficient manpower. The health professions, the communities, the states, regional planning groups, and Federal agencies all are involved. On the part of the Public Health Service, we are in-

terested in encouraging, through advice and funds, activity which will help to close the gaps and eventually eliminate them entirely.

With specific reference to Medicare and the implicit promise that services as well as financing will be available, the following remarks describe the situation as we see it today.

Medicare will increase the demand for hospital care by the elderly. In some areas it will be more difficult than in others to cope with the increased demand, but on a National scale, we have the capability of meeting the need. It has been estimated that the demand for hospital care by the aged may rise by as much as 20 percent, resulting in a five percent overall increase in utilization by the population of all ages. The occupancy rate of hospitals currently varies considerably according to geographical, urban-rural, and other factors. Nationally it is estimated to be about 75 percent. In some cities it's up to 80 or 85 percent. In some hospitals, it's almost 100 percent right now. But, on a national basis, our hospitals should be able to absorb the increased utilization that Medicare may bring. The first few months may be a difficult period.

With regard to skilled nursing home beds in extended care facilities, it is impossible to say today whether or not we will have enough to meet all National needs when this benefit begins on January 1, 1967. We are months away from any realistic prediction. But it should be noted that considerable activity has taken place in the past five years.

Five years ago, a Public Health Service survey found a National total of 362,000 skilled nursing care beds in nursing homes and related facilities. As of March 1 of this year, the American Nursing Home Association, in a survey designed to provide comparable data, reported 565,394 skilled nursing care beds. It is estimated that 40 percent of all nursing home beds have been built in the last five years and most of the newer facilities are larger than the old ones. The larger homes lend themselves to higher standards of patient care. In 1954, the average nursing home had 19 beds; the number of beds in a newly constructed nursing home is estimated at 57 by the Association.

One of the most exciting developments of the Medicare law is the support it has given to the development of home health services. It has long been known that many aged persons are in hospitals or nursing homes not because they needed intensive care around the clock but because there is no other resource in the community for providing the care they needed. Last October, Congress approved a Home Health Services Formula Grant Program to assist the states in developing these services for Medicare. As a result of this new grant and earlier efforts dating back to 1961, home health agencies are expected to exist by July 1 of this year in communities where perhaps two-thirds of the aged live. We will have a good beginning that will serve as the foundation upon which home health services can be expanded in response to the needs of the entire population.

We all know that physicians are in short supply. But the problem is reducible. The Health Professions Educational Assistance Program already has provided grants-in-aid to eight new medical schools.

Fourteen new schools are being developed and six others may follow. The private and public loan and grants program to assist the medical student offer important supports.

Nurses also are in short supply. But the Nurses Training Act of 1964 is beginning to attract more women to the profession and to help prepare graduate nurses for jobs as administrators, supervisors, or teachers.

Another encouraging development in the nursing picture has been the rekindled interest of nurses who have left the profession to raise families. In 1963, the Surgeon General's Consultant Group on Nursing estimated that half a million women trained as professional nurses were not practicing. Recently, I saw figures from surveys of 10,000 nonpracticing nurses in a dozen states. Forty-four per-

cent of them — more than 4,000 of these nurses — indicated they would like to return to work. Early this year in Ohio, questionnaires were sent to 4,000 inactive nurses, asking their availability and interest in returning to work. In the same letter, the state offered refresher courses to those who were interested. This produced 2,000 responses indicating interest. Most were particularly pleased with the opportunity to precede their re-employment with refresher courses.

Concerning the allied health workers such as medical technologists, biomedical engineers, physical and occupational therapists, and others forming today's health team, President Johnson has recommended a three-year program to provide grants for training, facilities, construction and improvement, and the development of new types of health personnel.

So we do have problems, but together we are all trying to do something about them.

Thank you very much. (Applause)

Dr. Howard: After this law was enacted by the Congress, the American Medical Association urged the National Association of Blue Shield Plans and the Health Insurance Associations of America to offer to serve as intermediaries in the administration of this program.

The next speaker is Director of Industry Relations for the Prudential Insurance Company. He will tell you about their role in this state. Prudential here is the Intermediary Carrier representative under Part B and also under Part A for 38 different hospitals.

The Carrier acting as an intermediary does not have an enviable task. I would urge all of you to work as closely, sympathetically, and helpfully as we can with the Carrier — in this case the Prudential — in other states the Blue Shield or whatever it may be in whatever state — because they certainly need very close cooperative relations with the profession.

Mr. White. (Applause)

Mr. William C. White: Thank you very much. I'd like to extend to the members of The Medical Society of New Jersey congratulations on the 200th anniversary of the Society. As we celebrate this anniversary, I think that looking ahead we stand at a time of great change. You have just heard from Mr. Hess about change in financing health care. Public Law 87 and Title 19 are going to have an effect on the financing of health care for people *under* 65. You have heard from Dr. Cashman about some of the changes you might look for in the pattern of the way care is provided. Let me tell you about a new role for the Prudential, which also is being shared by other insurance companies and Blue Shield Plans throughout the United States, in serving as the Carrier under Part B for the Medicare Program.

Why did the Prudential become involved in this "not-for-profit" operation? The Government under the law will pay us only our reasonable costs for administering the program. There are two reasons why we as a company are interested in becoming involved. First, in our company there is certainly a deep sense of public responsibility. As the second largest insurance company in the world, we are sort of forced into that position. Perhaps many of you do not know that six of our Board members are appointed to represent the public — appointed by the Chief Justice of New Jersey.

Second, I think that because of the effect that Medicare will have on the financing and the provision of health care, we must be concerned with knowing what is going on because it will affect the other business that we are involved in — health insurance business and particularly our group business. So we did offer our services to the Government, indicating that we were available in all fifty states in which we operate. We were selected for New Jersey. That is why I'm here today.

Under Part B, the law provides that the Secretary of HEW may name a Carrier to assist in the efficient and effective administration of the program with the following five responsibilities delegated to each organization chosen: to determine the amounts of pay-

ments due for medical and other health services in the geographic area assigned to each carrier; to assist persons who furnish the services for which payments are made in the development of procedures relating to utilization practices; to assist in the application of safeguards against unnecessary utilization of such services; to serve as a channel of communication between the Social Security Administration and the physicians and other persons furnishing covered services; and to perform such other services as may be agreed upon with the government.

The Secretary of HEW named the Prudential as a Carrier for New Jersey. This means that we will be processing claims involving the services of New Jersey physicians. Any beneficiary from New Jersey who crosses the river to New York or to the other side to Pennsylvania will have to look to the carriers in those areas for the processing of claims for services involving physicians in New York or Pennsylvania. We are the intermediary between the physicians and the Social Security Administration in the administration of this program rather than between the Social Security Administration and the beneficiaries. This is a major point and certainly one that you will need to know in discussing the operation of this program with your patients.

We will center our administration of both Plans A and B in Millville, New Jersey. We have an office there with space available for this purpose. It's been in existence for quite some time. It's quite a large office, and for several reasons we felt that it would be a good idea to place the administration there. We do have a favorable labor market in that area, and we already have employed additional people in order to process this new program. In recognition of the need for the Prudential to work closely with organized medicine, we have held meetings with the officers and members of the Board of Trustees of The Medical Society of New Jersey, and we have had meetings with the officers of all the county medical societies. A committee of MSNJ has been appointed for continuing liaison with the Prudential. We will have to work closely with the State Society, county medical societies — in fact with individual physicians — to make the Medicare program work effectively for the benefit of the aged beneficiaries.

There are several important points I want to stress to you today about both Parts A and B without getting involved in the details of the administration of the program. I want you to know, however, that I will stay and answer any questions that you may have after we have completed the program.

Under Part A, the hospital insurance program, *no benefits can be paid for physicians' services,* except salaries to interns and residents under approved training programs. For the hospital-based physician specialists — such as the radiologist and pathologist — bills must be rendered to, or on behalf of, beneficiaries for the identifiable personal services of the physicians. The benefits will be paid subject to the deductible and co-insurance provisions under Part B.

Beginning July 1, the Medicare pattern of health insurance benefits will become the standard for health insurance programs for *persons of all ages.* Group insurance plans covering persons under age 65 will be expected to change to the point they provide benefits at least equal to those of the older employees or retirants. So, in addition to the immediate impact of the Medicare program providing benefits to persons over age 65, there will be this effect on the health insurance benefit programs for *all other persons throughout the country.*

The Carrier has the primary function of determining "reasonable charges" on which benefits will be based. The Social Security Administration has provided the Part B Carrier with a draft document for discussion purposes describing the approach to be taken in the determination of reasonable charges. Naturally, the Social Security guideline must reflect the language of the law. Within that, the Carrier is required to take action to assure that physicians' charges on which benefits are based are reasonable.

The Prudential, along with the other carriers involved in this program, anticipate that the usual practice of the Carrier will be followed in the administration of Medicare. We have had long experience in the administration of major medical insurance policies in which there are no fee schedules. Under these policies, we are bound to provide payment on the basis of the usual, customary charges of physicians, so long as such charges are reasonable in amount.

The most important provisions in the law, therefore, for you are these: In determining the reasonable charge for services there will be taken into consideration the customary charges for similar services generally made by physicians or other persons furnishing those services as well as the prevailing charges in the locality for similar services. The "reasonable" charges must not exceed the level of charges used as the basis for payment of benefits to the carrier's policyholders under comparable circumstances.

You have three tests: Is the charge usual and customary to the particular physician? Is it consistent with the prevailing charges in the locality for similar services? And does it meet the third test about not exceeding payments made by the insurance carrier under comparable circumstances to its policyholders?

Within those guidelines we must take action to determine the "reasonable" charge and pay benefits. Payment of benefits will be made on one of the following bases: First, payment may be made directly to the beneficiary to the extent of eighty per cent of the reasonable charges, above the annual deductible, upon presentation to the Carrier of a receipted bill; or second, payment may be made directly to the physician of eighty per cent of the reasonable charges above the annual deductible if the doctor accepted an assignment from the beneficiary; but under such circumstances the physician must agree to accept the Carrier's determination of what is a reasonable charge as the full charge for the service. In this approach, there is this one important qualification that under the assignment the physician must agree to accept our determination of what is reasonable as his full charge.

The Form provides, first, that the patient must take positive action to assign the benefits; and second, the physician must act to accept the assignment. So that on the form the doctor has to indicate "I accept" or "I do not accept assignment." Instructions on the claim form indicate to the physician the fact that when he does accept the assignment he agrees to accept the reasonable charge as his full charge. This is a very simple form; it's a one-page form. You fill out one side, with instructions on the reverse. I think you will be pleasantly surprised, if you haven't seen it, to see that it is so simple.

If the patient pays the physician and presents a receipted bill to the Carrier, the patient may find that the Carrier is making its benefit determination on a basis other than the charge rendered by the physician. If the patient is not satisfied with the Carrier's determination of benefits, the law provides the patient is entitled to a fair hearing. This is a formidable and expensive procedure, since the hearing officer must be an attorney or other individual competent to conduct a formal hearing. We certainly hope to minimize the number of such hearings.

We will be able, with your help, to work with organized medicine in New Jersey in the establishment of the necessary committees as advisers to the Prudential. Under the major medical policies that the insurance carriers have been writing, review committees have been established in many areas to provide advice as to what the usual and customary charge might be under a given circumstance. Committees similar to this will be helpful to us if we run into situations where we are not sure what the usual and customary charge might be. This is in no sense a complaint procedure; this is a procedure under which we might have to seek advice from you as to what the usual and customary charge might be or what the prevailing fee might be in a given area so that we can properly process the claim and minimize the need for these hearings.

If the patient is to be billed directly, sufficient information must be provided, along with the receipted bill, so that we can process the claim without engaging in a lot of correspondence with you.

If the paid, itemized bill presented the patient provides sufficient information, it will not be necessary for you to complete the "reported services" portion of the government claim form. However, many physicians' billings do *not* provide a full description of the service rendered or the nature of the illness or injury requiring the physician's service. Yet, this is essential for us to have to process the claim.

You may want to consider the possibility of using the government form for *all* billings to patients over age 65 in lieu of whatever form you are now using. If the patient pays the bill, you can indicate on the form that the bill has been paid. If you have completed the required information there, we can process it. On the other hand, if you are going to accept "assignment benefits," you would have to use this form in any event. So if you use the form in *all* cases for your patients over 65, you will minimize the need for additional correspondence or the need to furnish additional information to us.

How do we determine when the deductible has been met? The Social Security Administration office in Baltimore will serve as the central source of information to all the Carriers, both Parts A and B. In their computer system they will store the records on prior utilization of each beneficiary. As these people move around the country, going to Florida for a vacation and perhaps back to New Jersey and perhaps incurring medical expenses in Florida and in New Jersey, we will find out what is happening by calling Baltimore and receiving a report on prior utilization. Thus, we will know whether the deductible has been met in full or partly, where we stand so we can properly handle the claim.

This can be done very efficiently, just the way it's planned. We can have a 24-hour response from Baltimore, anticipated each day to process the bills presented to us. The bill will be furnished on a magnetic tape from our computer. We can interrogate the computer in Baltimore, and the next day we'll have the tape back replying to that, so we can process these claims very rapidly. As they are processed, we can get the checks out to you.

I suggest that you adapt your billing procedure to the particular situation. Certainly, if it's an itinerant, you will want to render a bill immediately. On the other hand, if this is one of your old patients, with our continuing services you may want to follow your usual billing practice once a month or whatever you do. But there is no rule that you have to fit your billing practice into in that regard.

We, too, have a common purpose with the medical profession. We have been working with you gentlemen for a long time in voluntary health insurance. I think that we are all interested in the continuation of voluntary health insurance and voluntary medicine. I think that we need to work together to solve some of the problems that are bound to come up in this program in order to preserve both.

Prudential stands ready to assist you in any way we possibly can. In turn, we ask for your assistance in the establishment of the necessary advisory committees or any other committees that may seem necessary as this program gets underway. We think that working together we will be able to solve these problems as they arise with a minimum of impingement on the free practice of medicine in New Jersey. Thank you very much.

(Applause)

Dr. Howard: This completes the panel. It would be interesting to open this to the floor for questions, but I think you'd all agree that at this time, almost five o'clock, the best thing we can do is thank the panel and adjourn the meeting. Thank you very much.

(Applause)

(The meeting was adjourned at 4:45 p.m.)

MEDICAL-SURGICAL PLAN

Saturday, May 14, 1966, 5:30 p.m.

Nicholas F. Alfano, M.D., President of Medical-Surgical Plan of New Jersey, presided.

Dr. Nicholas F. Alfano: Last year, there was some talk about whether we should continue with these sessions. I felt a little in doubt because so few attended. Yet I was given another interpretation to the effect that so few people remained because they haven't any faults to voice concerning the Medical-Surgical Plan. I hope that was true.

Recently, there came to my attention a paper that had been presented by one of the Plan's Trustees. His opening was so appropriate to this occasion that I'm going to borrow it. He quoted a French proverb which says, "He who stands still is left behind." Today, more than ever before, mounting external forces are working on us to make us move. These pressures will continue to increase rather than slacken. Move we must. Blue Shield *cannot* stand still and be left behind. The problem no longer is *whether* to move, but in what direction and by what mechanism.

The most pressing matter confronting us is that of providing a special program of liberalized Service Benefits, along with an augmented fee schedule, to certain National Accounts. This is set forth in the Plan's supplemental report to MSNJ, which has been distributed to all delegates and which you have had the opportunity to read. I urge that you support the proposal at the hearing of the reference committee tomorrow morning. Let me emphasize that such a program is vital to the Plan's well-being. In this case, we will surely be left behind if we stand still.

The impact of Medicare is another matter of great significance. Blue Shield was passed over when the Part B carrier was designated for New Jersey, despite the strong endorsement of the Medical Society .

The Plan is still involved in the Medicare picture in a complementary role. The implications here are still far from clearcut, but we can draw some general conclusions. The transfer of our 65-and-over members from community rating (where they represent a high loss ratio) to special complementary programs that are underwritten, should ultimately be of some benefit to the Plan's financial structure, although to what degree it is impossible to foretell. On the other hand, the complications of meshing the complementary programs with Medicare coverage will require some additional expense for such matters as increased staffing. We expect to be advising the profession, quite soon now, of the details of the complementary programs, the procedures for submitting claims, and other pertinent information.

Whatever financial benefit may accrue to the Plan because of Medicare is sorely needed. If you have read the Plan's annual report, you know that our fiscal position is approaching the precarious. With minimal reserves, we are caught in a three-way squeeze: the market is constantly seeking broader coverage and more liberal Service Benefits; utilization by members continues to rise at an accelerating rate; we are tied to an obsolete premium that was realistic when it was established five years ago.

Why, one might ask, did the Plan not first seek a premium increase before introducing additional benefits and adjusted fees last Fall? This certainly would seem to make sense; but unfortunately, not in Trenton. The prevailing philosophy there has been that rate relief will not be considered even when a Plan's reserves are down to only *two weeks* of operating expenses. This contrasts with the National Association of Blue Shield Plans' criterion of *three months* operating expenses as a minimum adequate reserve.

The fact that we have come this far on a rate established in 1961 is in itself unusual. Hopefully, the transfer of Medicare-eligible persons to a self-sustaining basis on July 1 may give us a little more breathing space later on. But eventually we must adjust to the dominant forces of the time.

While Medicare may offer some slight relief in one area, it is creating problems in another. The wide scope of coverage provided under the Federal program already is impelling some of the younger groups to ask why such a program should be limited to the old folks — why can't they get the same sort of thing from Blue Shield? This reaction is acting as a spur to a market which even before Medicare was seeking broader coverage.

So the consumer is demanding broader coverage — and he will get it, if not from Blue Shield, then elsewhere. He is demanding more Service Benefits coverage through liberalized income limits. At the same time, fees must be kept adequate, both in relation to the medical economy — which already gives hints of inflationary pressures from Medicare — and to liberalization of income limits for Service Benefits. Where National Accounts are concerned, the authority to experience-rate is a saving factor in meeting the mounting costs. But for the great majority of the Plan's business, the outgo is currently exceeding the income. The demands of the market point to increased outgo.

These are some of the concerns we share. The one clearcut fact that confronts us is we must move, or be left behind.

We are now open for discussion. Several of the Plan's Trustees are present today, and I cordially invite them to enter into the discussion — particularly on topics brought up from the floor that relate to overall philosophies and policies of Blue Shield. Thus, the discussants may have the benefit of the views of these men who unselfishly dedicate much of their time and effort to guiding the destiny of Blue Shield.

Question From Floor: Would you discuss a little bit the basis by the Federal government for the selection of carriers under Part B?

Dr. Alfano: It would be conjecture on my part. We wrote to the Government, requesting specific information as to what had, in the information we submitted, caused the government to bypass us. We just got some soothing words from them that the nonselection of a particular carrier in an area does not mean that that carrier had not the ability or the resources to carry on the program. The law itself requires that carriers will be selected from various types of insuring organizations. Thus, they had to make a choice of different types of carriers from different states. And we know that many other insurance companies are involved in the carrier roles as well as other types of health care plans. I couldn't tell you specifically if there were any reasons why we were not selected.

I hope most of you can be present at the Reference Committee "C" tomorrow morning. We know the recommendation that is being presented is a drastic move for a plan to take and for this Society to consider.

Dr. Alexander H. Fishkoff (Middlesex): You mentioned the philosophy of the service plan. When it originally came into being, it was based upon one thought only: to help those in low income groups. If we change our philosophy, we are getting into a different field entirely: new in concept, new in ideas. We've got to be cautious before we turn to that field. Most of us physicians went along with the Plan's ideas because we were interested in the low income groups. Those who participated in the early days went because of the philosophy that was promulgated — low income. Now, if you are going into the higher income group, it must be based on another philosophy. Is the philosophy going to be based upon so-called "inflationary" low income groups who are now getting a little more income but who are still in the lower bracket because they have a tough time getting along in our so-called economic way of life?

How far are we going to go in these service benefits? Are we going to go into the 20, 30, 40,000 dollar groups as well? Why not consider an indemnity plan along with the service benefits which will be maintained for what we have now in the $7500 groups?

Consider third-party liability and multiple insurances which I have, over the last number of years, called to your attention. I know you have no answer except to tell us to go to the Legislature. I think the Plan itself should make an effort now, as I said previously, to document all the necessary provisions favorable to a presentation to the Legislature of why we should have it, the needs for it.

Then I asked a couple years ago — and I think the House of Delegates went along with this — about getting activation of the MS representative from each county society to the MS Trustees or to the MS Plan itself. Nothing has been done about that that I know of. No meeting has been held in the last few years with any representation from the several counties. Is that true? Can you answer that directly?

Dr. Alfano: Representing county medical societies?

Dr. Fishkoff: In other words, there are two or three in each county society who were supposed to represent the society in matters pertaining to the MS Plan. Has any meeting been held?

Dr. Alfano: Not with those groups; but we continuously have meetings with specialty groups or any group that requests a meeting.

Dr. Fishkoff: That's been going on for years. My understanding was that we would activate a broader scale of participation from each society, so that the representatives from the county can go to you people with their gripes and recommendations. Then we would have a broader unit of participation in your discussions. There are many questions that come up individually that can't be answered here because these men don't come to these meetings. They don't take the time off. They can't get here. The delegates are the only ones who come here. I'm not a delegate this year, but I'm interested and I come here — as I will be, as long as I live, I hope. That is one thing I am very much interested in—and have been for some time — to urge participation by the representatives in the counties. Then we would go to you people yearly, where you can discuss a lot of these problems and come out with a greater degree of knowledge than you have right now.

How about this catastrophic type of policy which a lot of insurance companies have? Isn't it possible for the Plan to participate in a catastrophic type of insurance, probably bringing another carrier with it? Has anything been done about that?

Dr. Alfano: You are speaking of major medical. Major medical coverages require the ability to "experience-rate," which we don't have here except on a limited basis for national accounts. And we are not yet in a position to offer a major medical program. When that authority will be granted us, we have no way of telling.

For the past three or four years, the Dumont Legislative Commission has recommended to the Legislature the authority for Blue Shield to "experience-rate" intra-state accounts. But the Legislature has never given us that authority.

On the matter of the third-party multiple insurance, I refer you to the resolution adopted at the last annual meeting — "The Medical-Surgical Plan Contract Inequities," I believe, was the title. At the time we were considering a revision of the contract, this was approved and became effective on October 1st with the adjusted schedule of fees. In our preliminary draft of the new contract, we have included a provision which would waive the participating physician's agreement to accept Plan payment as payment in full when there was other insurance or when there was third-party liability. The Commissioner again was adamant. He says he will *not* approve any contract if that provision remains in it. We had to make a change. To make the change as quickly as possible, we had to delete that provision and go back to the old standard. We felt it was in order that we make our change in contract and in the schedule, since we were not in a competitive position with

several areas around in the payments we were making under the old schedule. We had to come up to date, and we did that without any great change.

Benefits were increased under the new contract, effective October 1st. These were in addition to benefits imposed upon us by legislation — dentists' payments. We have now included care of the newborn as an eligible service. We have eleminated the $50 maximum for care of accidental injuries out of hospital, and so on. These are all extended benefits. We are still on the old 1961 rate. So at times we are prevented from moving as fast as we would wish. We have state agency control, so that some of the things we are requested to consider — and possibly include in our operations — can't be done after conferences with the Department of Banking and Insurance.

Dr. Fishkoff: Yet you have in effect today multiple contracts that are so apportioned that payment is only made in full amount in two or three carriers' contracts. Now, he permitted that, apparently. It's there.

Dr. Alfano: Among the commercial companies; that's correct.

Dr. Fishkoff: If he's permitted that — and they are in business to make money, whereas we are not — that is certainly most irregular.

Dr. Alfano: I didn't comment on the propriety of the difference in the handling of a medical service corporation and the commercial companies. First, a commercial company can apply whatever rate they want to a contract. This doesn't need the approval of the State Department of Banking and Insurance. There are many things that commercial companies can do that we are prevented from doing, and we are under the strict surveillance and control of the Banking and Insurance Department.

How about our basic philosophy? Well, like everything else with the changing of the times, since 1942 the Plan also had to change. We now know that prepayment health coverage is certainly *not* limited to low income groups. What is low income? With the adoption of the new welfare law in New York, a person with $6,000 annual income is considered "indigent." They practically put a definition on that through the new law. And I don't know how far this will go.

Dr. Fishkoff: Is it possible to consider a combination of indemnity plus service plan as well, a combination under one contract?

Dr. Alfano: Since there will be practically no indigents—the government will see to that under Title XIX—the practicing physician will not be giving his services away to the extent he has in the past. The day has to come when the doctor will have to determine what is an acceptable charge for his service *without regard to income.* More and more are coming to that. We can't determine any longer that we would have a multitude of contracts based on income for which there would be just payments along the line. The day is coming fast when the doctor will just have to charge what he believes is an adequate fee for the service, regardless of income.

Dr. Fishkoff: That can't always hold true, because there are some people who are more demanding in the higher echelons of income. When they are more demanding, the physicians who attend to them are certainly entitled to a greater return because it's far and beyond what the usual care is that illness may require. But these people do demand more. Why shouldn't they pay for it? Why give them across-the-board the benefits of a service plan? This is what my contention is.

Dr. Alfano: I was speaking in general. We know there is always the fellow who wants you to be his valet apart from his doctor, wants you to sit with him and all that, daily or several times a day. They are the exceptions. And of course, that type of patient should be willing to pay a higher fee.

Are there any other questions? Thank you very much for remaining.

(The meeting was adjourned at 6:00 p.m.)

ATTENDANCE

REGISTRATION OF HOUSE OF DELEGATES

Registration:			
Total Possible—Officers, Fellows, and County Delegates			366
Total Possible of County Delegates		345	100%
Total County Delegates Registered		324	93.9%

Attendance of County Delegates at the House Sessions:		% of Possible	% of Registered
1st Session, 5/14/66	(289)	83.8%	89.2% (*)
2nd Session, 5/15/66	(308)	89.3%	95.1%
3rd Session, 5/18/66 a.m.	(278)	80.6%	85.8%
p.m.	(248)	71.9%	76.5%
Average for All Sessions	(281)	81.4%	86.7%

(*—Highest on record)

Official Attendance Report

County	Delegates	Members	Total
Atlantic	8	66	74
Bergen	36	33	69
Burlington	7	24	31
Camden	20	36	56
Cape May	3	4	7
Cumberland	5	13	18
Essex	62	123	185
Gloucester	4	12	16
Hudson	27	37	64
Hunterdon	3	2	5
Mercer	23	46	69
Middlesex	18	25	43
Monmouth	17	37	54
Morris	15	18	33
Ocean	6	17	23
Passaic	28	45	73
Salem	3	13	16
Somerset	5	14	19
Sussex	3	2	5
Union	28	37	65
Warren	3	3	6
Fellows and Officers	18	—	18
	342	607	949
Physician Guests			73
Physician Exhibitors			2
TOTAL PHYSICIAN REGISTRATION			1,024
Auxiliary—Members, 413, Guests, 7			421
Visitors			403
Exhibitors			311
TOTAL REGISTRATION			2,159

FIVE-YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Total
1966	1,024	1,135	2,159
1965	1,109	1,046	2,155
1964	1,040	966	2,006
1963	1,018	973	1,991
1962	1,208	1,083	2,291

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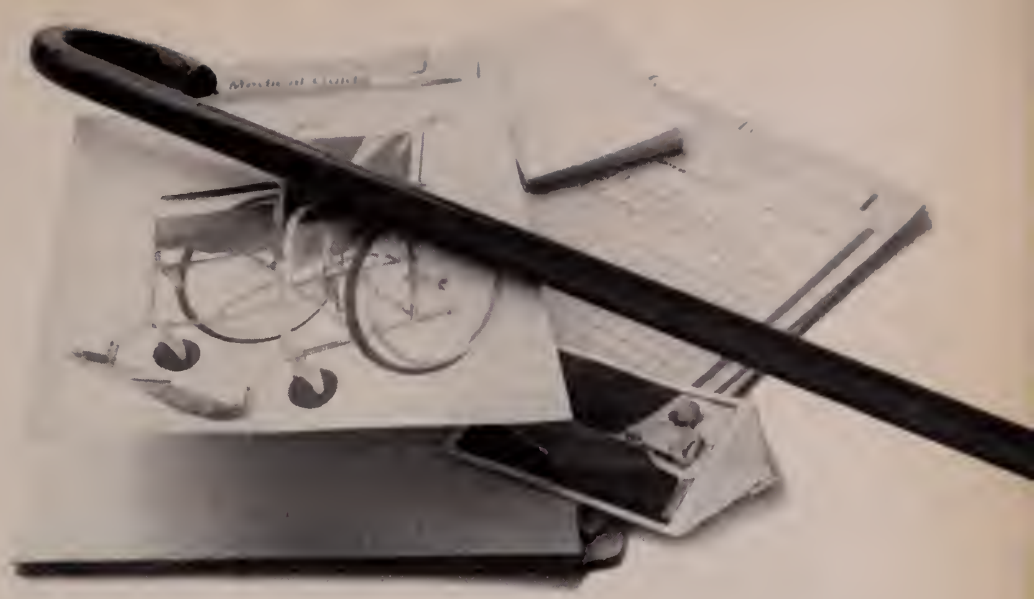


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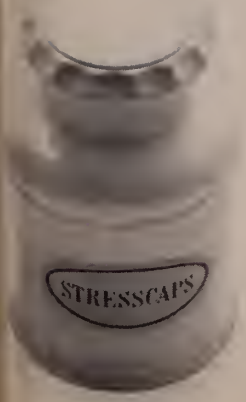
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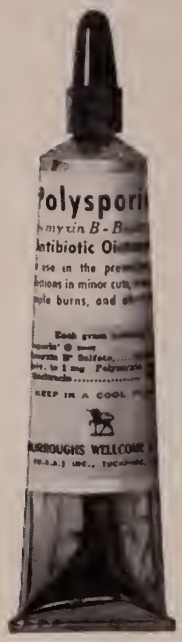
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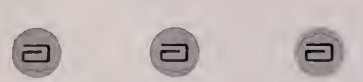
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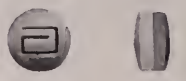
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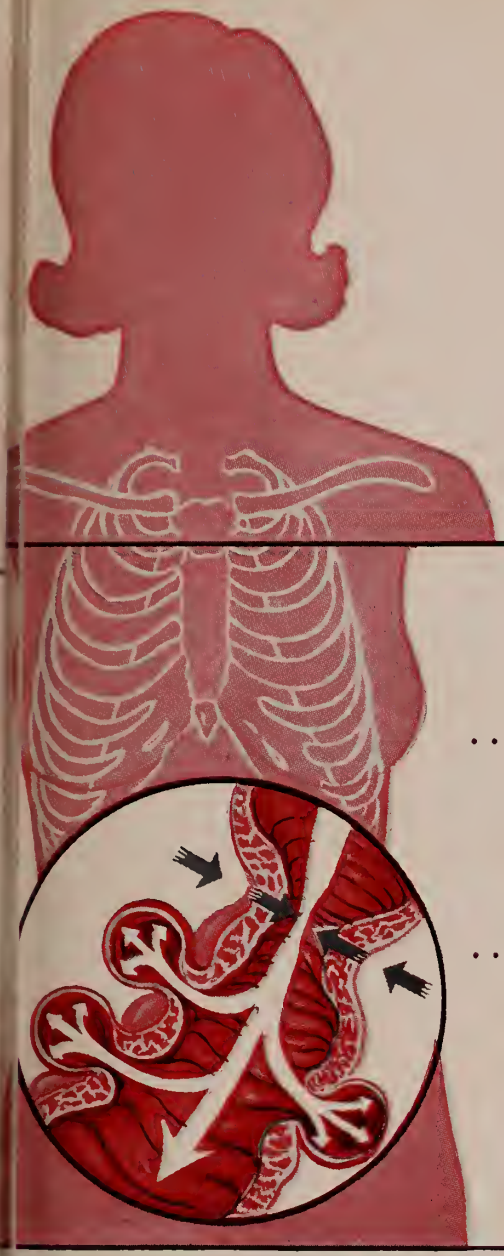
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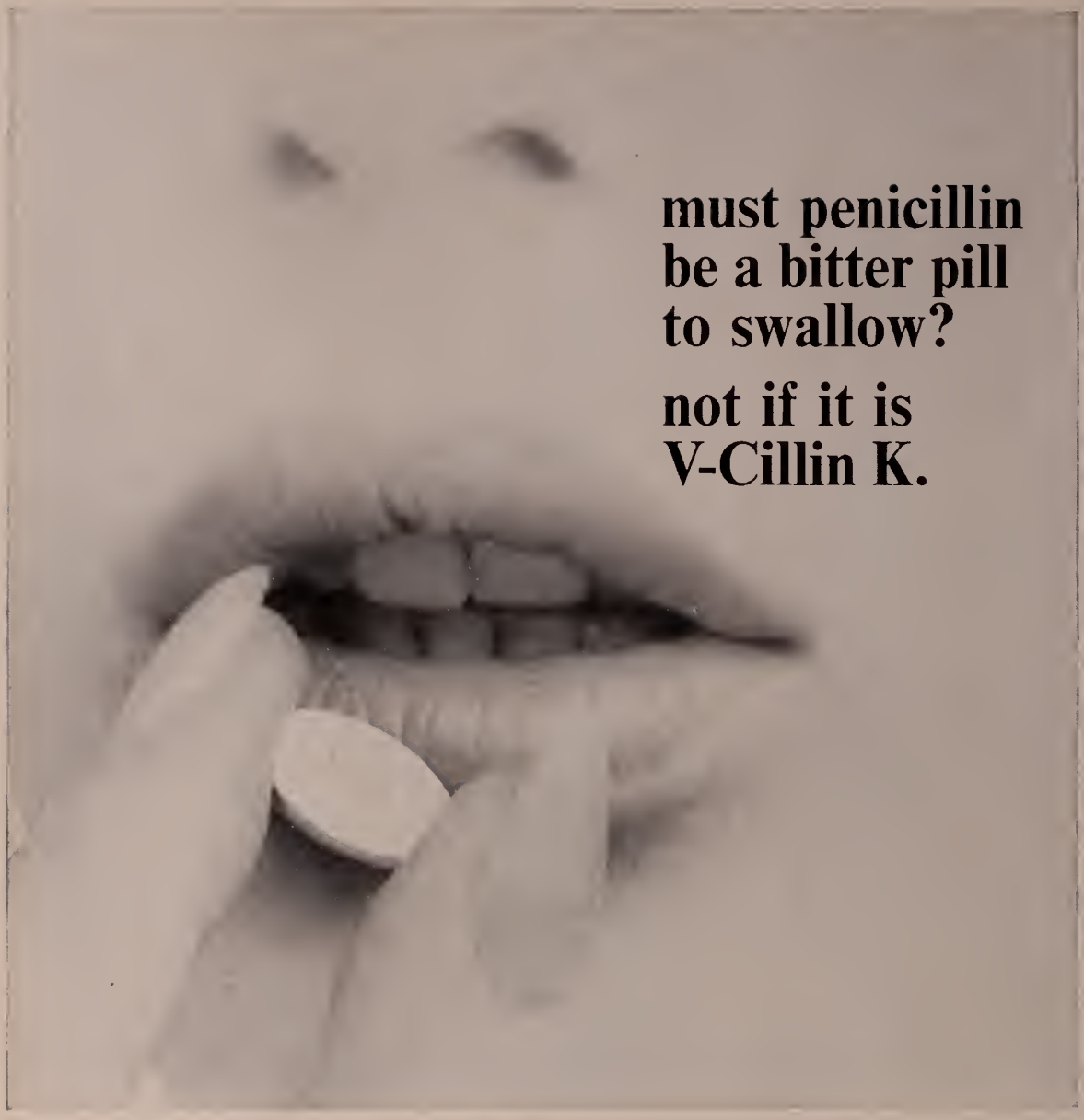
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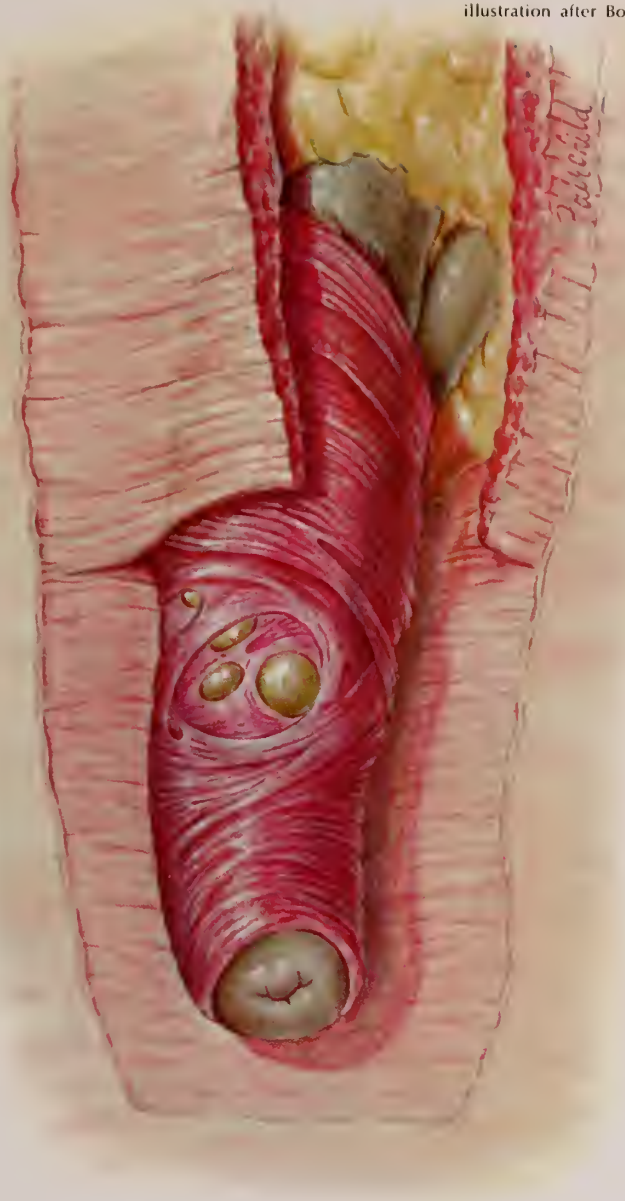
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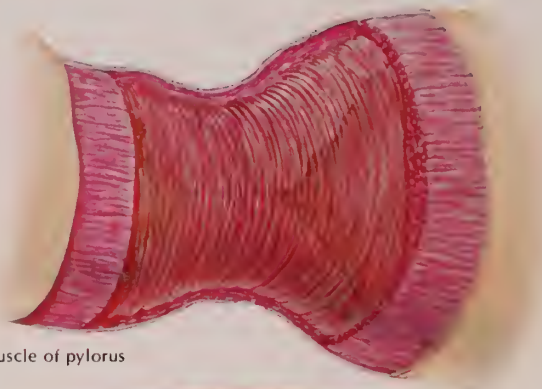
INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations. DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort. PRECAUTION: Caution is recommended when using in hypotensive patients. SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

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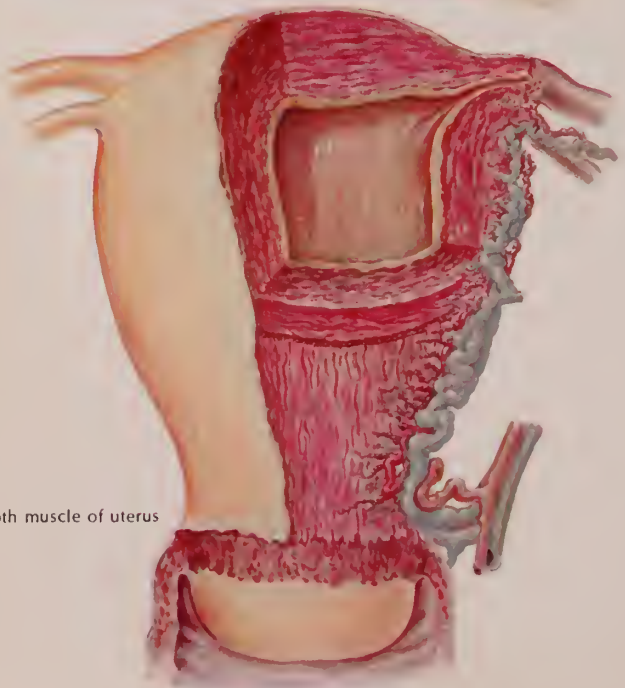
smooth muscle sphincter of Oddi



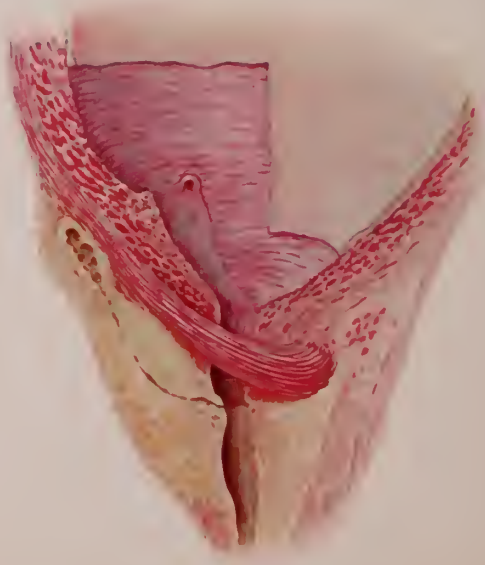
smooth muscle of pylorus



smooth muscle of colon



smooth muscle of uterus



smooth muscle of urinary bladder

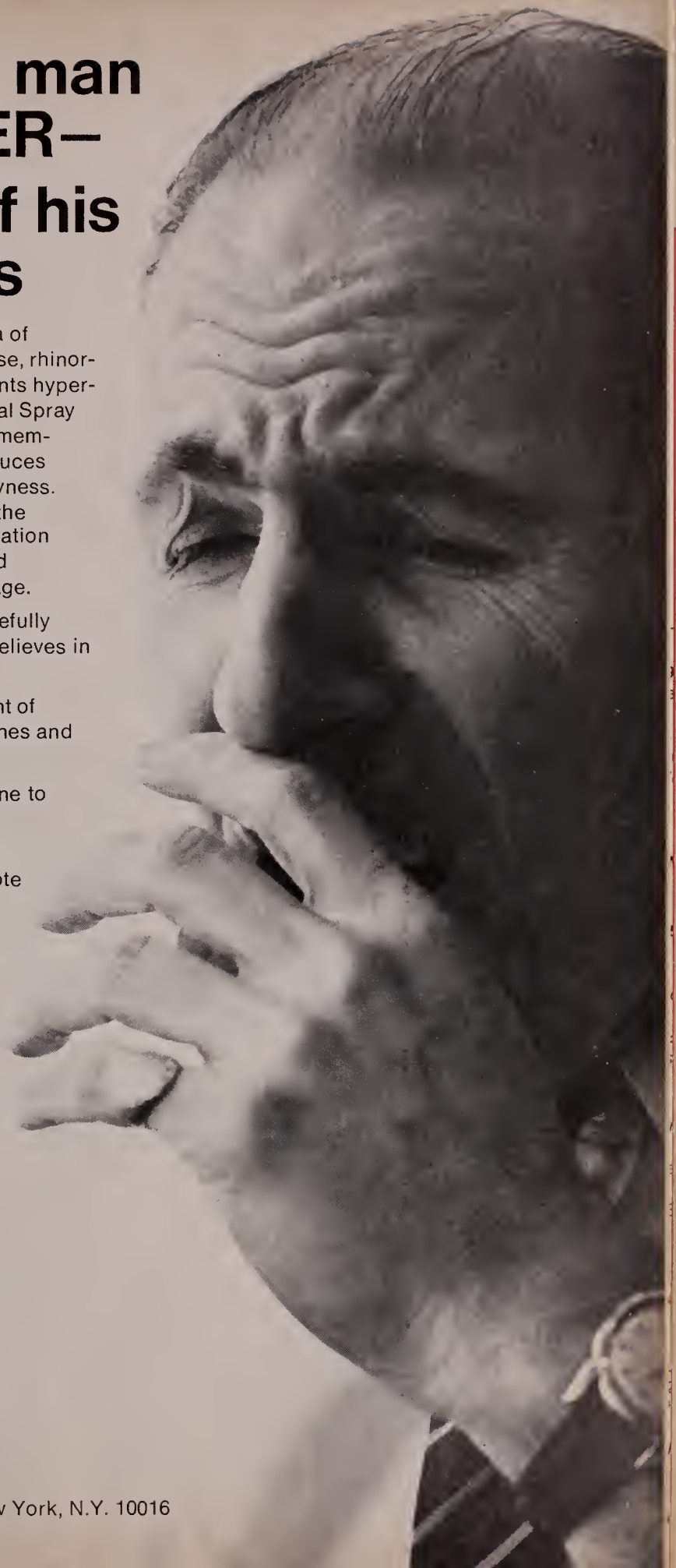
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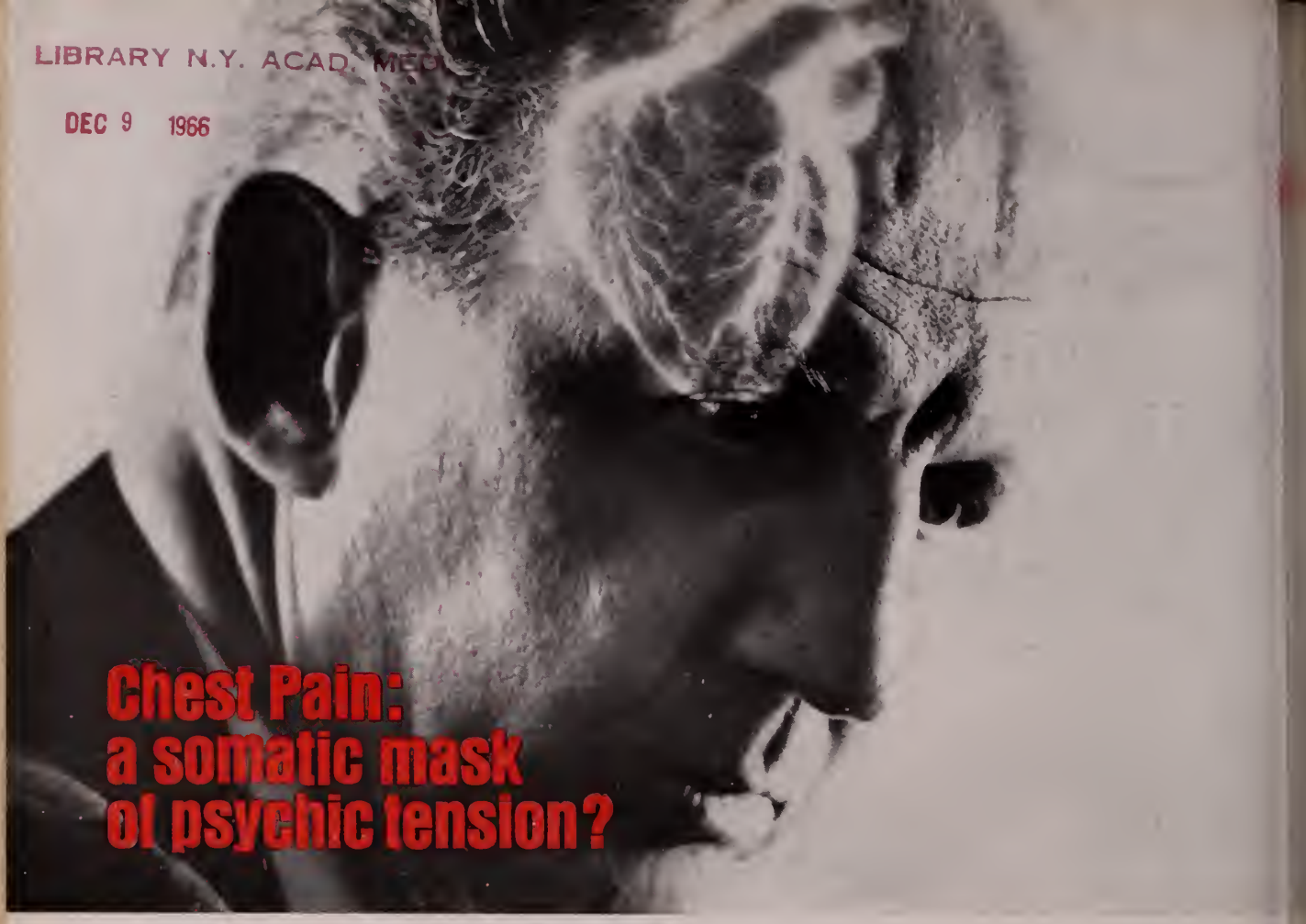
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Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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CONTENTS • Pages 409 to 448

EDITORIALS

Boldness About Baldness 409
The Pen Is Mightier 409
The Non-Emergency Room 410

ORIGINAL ARTICLES

The Road Ahead
Joseph R. Jehl, M.D., Clifton 411
Prevention of Athletic Injury
Francis I. Tomlins, M.D., Ridgewood 414
The Microspherule Concept of Coated Salicylates
Herman H. Tillis, M.D., East Orange 416
Tracheostomy Today
F. Robert Haase, M.D. and Julio T. Noguera, M.D., Neptune City 418
The Klippel-Trenaunay-Parkes Weber Syndrome
Martin H. Wortzel, M.D., Millburn 420
The Medical Review and Advisory System
Daniel F. Featherston, M.D., Asbury Park 423

STATE ACTIVITIES

Four Billion Dollars For Drugs? 415
Information For Readers 422
Trustess' Minutes: June 19, 1966 425
May 18, 1966 426
May 13, 1966 428
Cooperation With Bar Association 431
The Third Century Begins 433
Committees and Council 435
OBITUARIES 439
ANNOUNCEMENTS 441
LETTER TO THE JOURNAL 443
BOOK REVIEWS 445
RESPIRATORY DISEASES ABSTRACTS 447









816 — 1966



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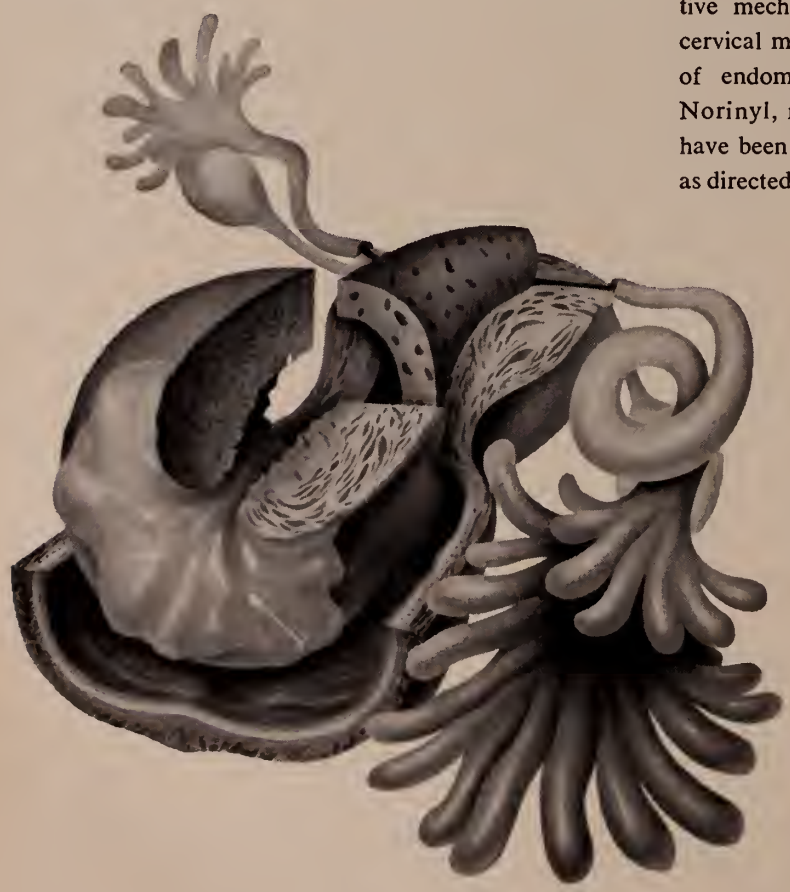
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Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187 664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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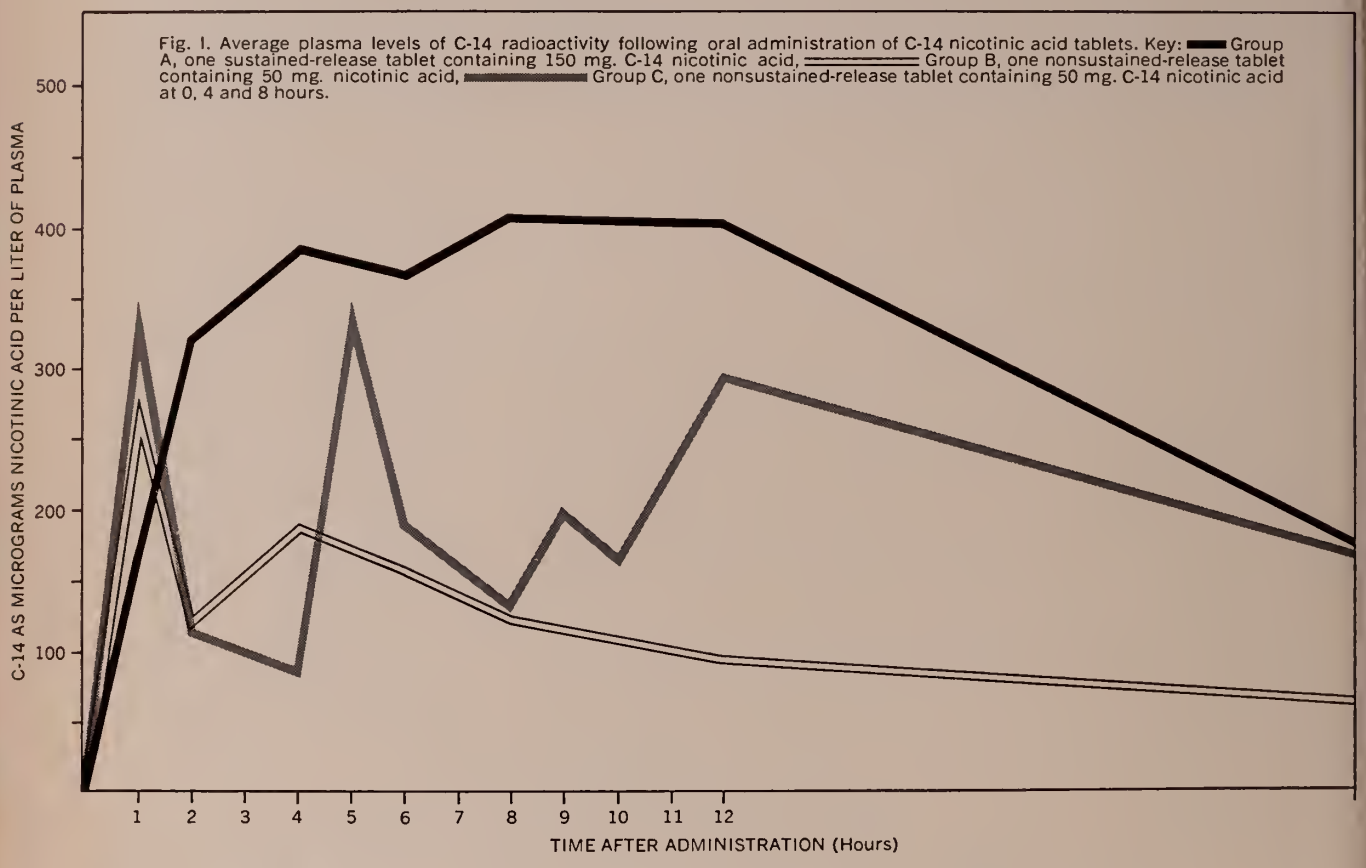
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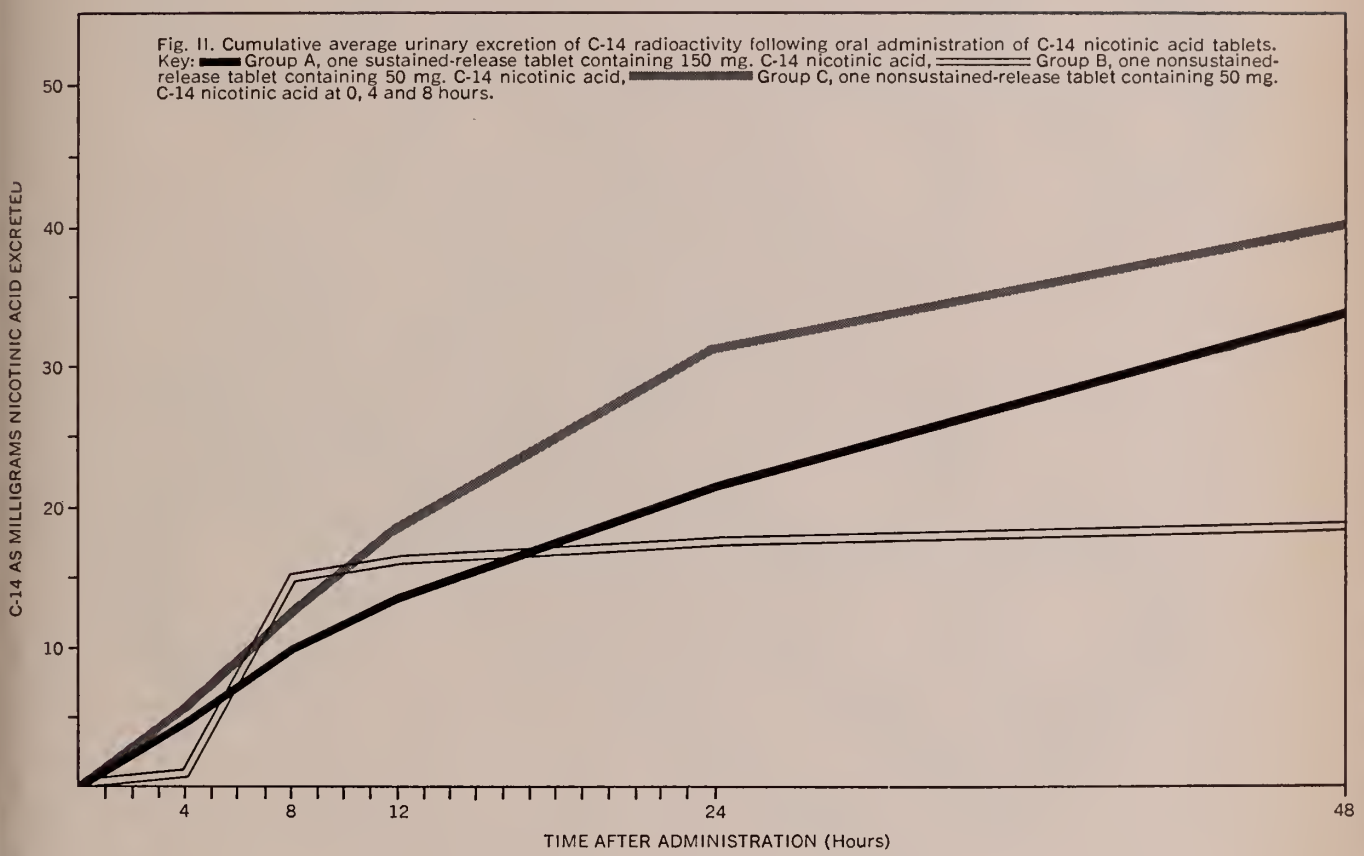


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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- **Ileostomy**
- **Gastroenteritis and colitis**

Dosage: For correct therapeutic effect—Rx correct therapeutic dosage. The recommended initial daily dosages, given in divided doses, until diarrhea is controlled, are:

Children: Age	Total Daily Lomotil Dosage	Lomotil Liquid Dosage (Each teaspoonful [4 cc.] contains 2 mg. of diphenoxylate HCl)
3-6 months	3 mg.	½ tsp. 3 times daily
6-12 months	4 mg.	½ tsp. 4 times daily
1-2 years	5 mg.	½ tsp. 5 times daily
2-5 years	6 mg.	1 tsp. 3 times daily
5-8 years	8 mg.	1 tsp. 4 times daily
8-12 years	10 mg.	1 tsp. 5 times daily

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) Based on 4 cc. per teaspoonful. Maintenance dosage may be as low as one-fourth the initial daily dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

Everyone says she's a barrel of fun



But what does she think?



Many overweight patients can benefit from the appetite control provided by the sustained anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action of amphetamine; tranquilizing action of meprobamate; prolonged action through sustained release of active ingredients.

Bamadex® Sequels®

DEXTRO-AMPHETAMINE SULFATE (15 mg.) WITH MEPROBAMATE (300 mg.) SUSTAINED RELEASE CAPSULES

to help establish a new dietary pattern

Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company,
Pearl River, New York

695-6



Butazolidin® alka

phenylbutazone, 100 mg.
dried aluminum hydroxide gel, 100 mg.
magnesium trisilicate, 150 mg.
homatropine methylbromide, 1.25 mg.

Usually works within 3 to 4 days in osteoarthritis

The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is *at least 1 month.*

That's why it's logical to start therapy with Butazolidin alka—you'll know quickly whether or not it works. And usually, it will.

A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

Contraindications
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should be used with greater care in the elderly and should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Use with caution in the first trimester of pregnancy.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information.
6509-V(B)

Also available: Butazolidin®, phenylbutazone Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York BU-3804R

Geigy



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown®
(meprobamate)

Indications: Meprobamate is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, meprobamate fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: 'Miltown' (meprobamate) is available in two strengths: 400 mg. scored tablets and 200 mg. coated tablets. 'Meprotabs' (meprobamate) is available as 400 mg. white, coated, unmarked tablets. *Before prescribing, consult package circular.*

WALLACE LABORATORIES
Cranbury, N.J.

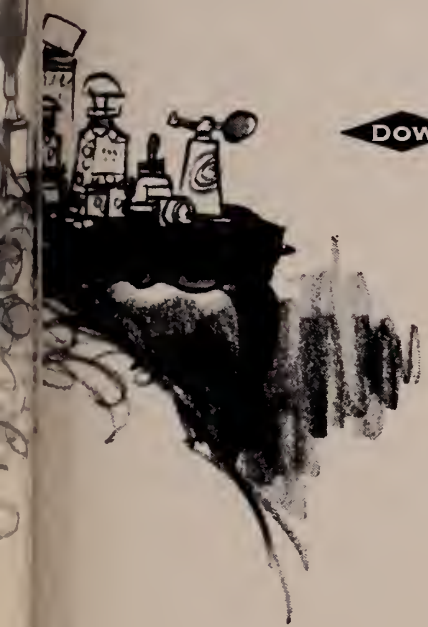
CM-7814



If you can hang on for a few minutes, Doctor, I'm sure I'll start coughing again.

Some patients don't realize there's more to a cough than meets the ear.
If it's the useless, exhausting type of cough that often accompanies respiratory infection or allergy, you can provide prompt relief with Novahistine DH. Its decongestant-antitussive action controls frequency and intensity of cough spasms without abolishing cough reflex And the fresh, grape flavor of Novahistine DH appeals to children and adults alike.
When your diagnosis is bronchitis, complicated by thick tenacious exudates, Novahistine Expectorant is particularly useful. It not only provides decongestive action and controls the cough, but also encourages expectoration, thus easing bronchial constriction and obstruction.
Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.
Each 5 ml. teaspoonful of Novahistine DH contains codeine phosphate, 10 mg. (Warning: may be habit forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, 2 mg.; chloroform (approx.), 13.5 mg.; l-menthol, 1 mg. (Alcohol 5%). Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

NOVAHISTINE® DH
NOVAHISTINE® EXPECTORANT



DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

new from Ames
5 basic uro-analytical facts in 30 seconds



Labstix®

BRAND REAGENT STRIPS

...broadest urine screening possible from a single reagent strip

Urine test results with LABSTIX Reagent Strips can represent significant guides to differential diagnosis or therapy in many conditions. An unexpected "positive" may enable you to detect hidden pathology—long before more recognizable symptoms become evident. Negative results, which permit you to rule out abnormalities in a broad clinical range, can serve as baseline values for reference in future examinations. The 5 colorimetric test areas encompassed on LABSTIX Reagent Strips are:

pH—values are read numerically in the essential range of pH 5 to pH 9.

Protein—results are read either in the "plus" system or in mg. % in amounts approximating "trace," 30, 100, 300, and over 1000 mg. %.

Glucose—provides a "Yes-or-No" answer for urine "sugar spill."

Ketones—detects ketone bodies in urine—**both** acetoacetic acid and acetone. Reacts with as little as 5 to 10 mg. % of acetoacetic acid.

Occult Blood—specific test for intact red cells, hemoglobin or myoglobin. Results are read as negative, small, moderate or large amounts.

Now a Clear Reagent Strip of Firm Construction

...facilitates handling during testing procedure. Excellent color contrast made possible by the clear plastic strip, together with the clearly defined color charts provided, permits precise, reproducible colorimetric readings in all 5 test areas. A more definitive interpretation of uro-analytical facts is made possible.

Available: LABSTIX Reagent Strips, bottles of 100 (color charts are supplied with each bottle).

Ames Company, Inc., Elkhart, Indiana

AMES

08165



Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary, prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: Obstet. & Gynec. *27*:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

SQUIBB *'The Priceless Ingredient' of every product is the honor and integrity of its maker.*

Anatomy of
Low Back Pain #1



the sedentary life is often the seat of low back pain

The human spine is not engineere fo
prolonged sitting at desks, pianos, pe
writers and drafting boards. The stre se
set up by the heavy, forward-tilted ac
and trunk, balanced precariously o ar
insufficient base, result in strain o he
dorsal musculature, particularly at h
low lumbar level.

*The unusual muscle-relaxant and al
gesic properties of 'Soma'* make it e be
cially useful in the treatment of low c
sprains and strains. 'Soma' is wi
prescribed ☐ **to relieve pain** ☐ **to r ax
muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for manageme o
muscle spasm, pain, and stiffness in a vari o
inflammatory, traumatic, and degenerative m su
loskeletal conditions. It also may act to norm iz
motor activity in certain neurologic disturba es

Contraindications: Allergic or idiosyncratic ac
tions to carisoprodol.

Precautions: 'Soma', like other central ne u
system depressants, should be used with ca or
in patients with known propensity for takin ex
cessive quantities of drugs and in patients it
known sensitivity to compounds of similar ch n
cal structure, e.g., meprobamate.

Side Effects: The only side effect reported witl ny
frequency is sleepiness, usually on higher ar
recommended doses. An occasional patient ay
not tolerate carisoprodol because of an indiv ia
reaction, such as a sensation of weakness. (Ie
rarely observed reactions have included dizzi ss,
ataxia, tremor, agitation, irritability, headach in
crease in eosinophil count, flushing of face, nc
gastrointestinal symptoms.

One instance each of pancytopenia and le co
penia, occurring when carisoprodol was ad in
istered with other drugs, has been reported, as as
an instance of fixed drug eruption with carisop lo
and subsequent cross reaction to meprobar te
Rare allergic reactions, usually mild, have incl ed
one case each of anaphylactoid reaction with lo
shock and angioneurotic edema with respira n
difficulty, both reversed with appropriate the y
In cases of allergic or hypersensitivity react is
carisoprodol should be discontinued and appr ri
ate therapy initiated. Suicidal attempts may o
duce coma and/or mild shock and respira n
depression.

Dosage: Usual adult dose is one 350 mg. ta e
three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tal ts
and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strai

SOMA
(CARISOPRODO

Wallace Laboratories, Cranbury, N
265

Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.



mood elevation

Abbott
Anorectic
Program

DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.



controlled release

Abbott
Anorectic
Program

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.



The release action is purely physical and relies on only one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric coatings, enzymes, motility, or an "ideal" ion concentration in the gastrointestinal tract.

Your patients get a measured amount of medication, moment by moment, throughout the day.

They are not subjected to ups and downs of drug release . . . or to erratic release from patient to patient . . . or to erratic release in the same patient from day to day.

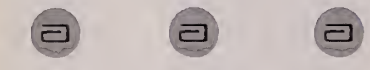
That's why the Gradumet provides controlled-release as well as long release.

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

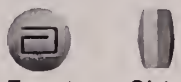
Abbot
Anorectic
Program

DESOXYN Gradumet
Methamphetamine Hydrochloride in Long-Release Dose Form



5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium



Front Side

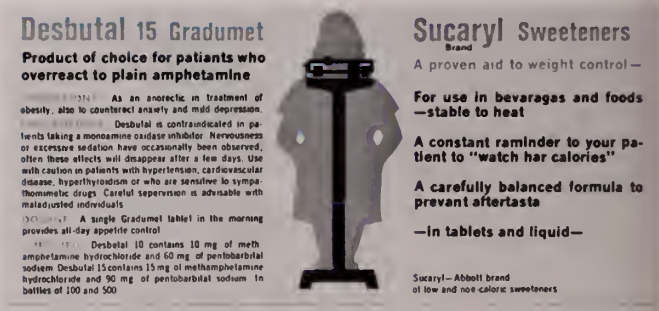
DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium

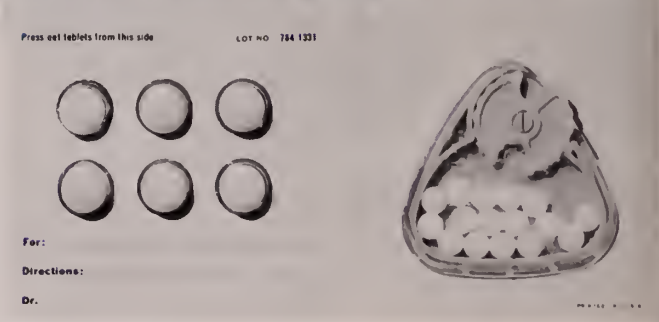


Front Side

samples available







Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.

economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

ABBOTT

Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
Sucaryl—Abbott brand of low and non-caloric sweeteners.

601060

Winthrop announces new WinGel®

ANTACID TABLETS AND LIQUID

For peptic ulcer, gastric hyperacidity, gastritis

Each WinGel tablet or teaspoon (5 ml.) contains 410 mg. of combined, highly reactive, short polymer, aluminum and magnesium hydroxides **stabilized with hexitol.**

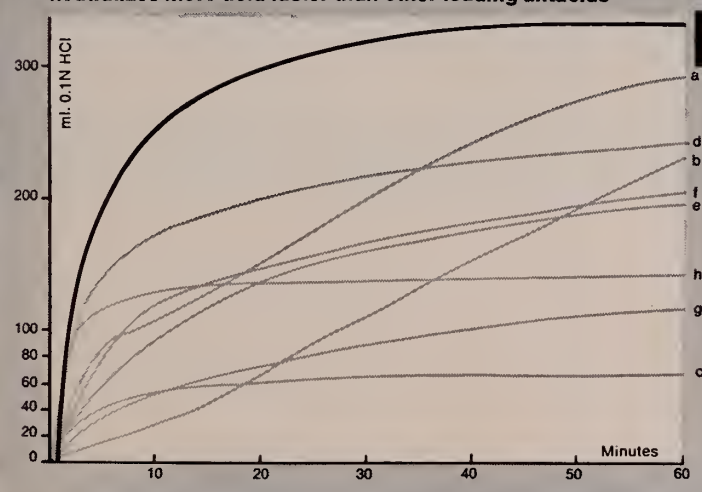
Neutralizes 300 times its active-ingredient weight in gastric acid for fast, long-lasting relief

Gastric or duodenal ulcer, acute or chronic gastritis, gastric hyperacidity...wherever there is "acid overflow" new WinGel can provide faster, longer, more complete neutralization.

In recent laboratory comparisons* with eight other leading antacids, new WinGel tablets not only neutralized more hydrochloric acid per active-ingredient weight, but neutralized it faster and longer than all other antacids tested.

Pleasant pink in color, WinGel is delicately mint flavored with a smooth-as-cream texture—qualities sure to please the patient on long-term therapy. New WinGel is also specially formulated to avoid constipation or diarrhea.

New WinGel neutralizes 300 times its active-ingredient weight in 0.1N hydrochloric acid—neutralizes more acid faster than other leading antacids



Rate of 0.1N hydrochloric acid neutralization at pH 3.5 and 37° with WinGel and eight other leading antacid tablets—*in vitro*. Samples equaled the weight of tablet material containing 1.0 Gm. active ingredients.*

*Hinkel, E. T., Jr. (New York): Data in the files of the Department of Medical Research, Winthrop Laboratories.

Dosage: Peptic ulcer or gastritis—from 2 to 4 teaspoons of WinGel liquid or 2 to 4 tablets chewed or allowed to dissolve in the mouth every two to four hours. **Gastric hyperacidity**—2 tablets or teaspoons about ½ to one hour after meals as needed; children from 7 to 14 years of age, 1 or 2 tablets or 1 or 2 teaspoons of liquid as needed.

How Supplied: Liquid in bottles of 8 fl. oz. and 1 pint. **Tablets** in cellophane strips, boxes of 50 and 100. (One teaspoon of WinGel liquid is equivalent to one WinGel tablet in acid-combining capacity.) WinGel, trademark reg. U.S. Pat. Off.

Winthrop Laboratories, New York, N.Y. 10016 Winthrop

Finally — a taste your patients will truly like

(1058M)



The synthesis of cortisone was accomplished by Merck Sharp & Dohme in 1948—the famous "Compound E" used by Dr. Philip Hench in his historic experiment at the Mayo Clinic.

But proud as we are of our role in the development of cortisone and subsequent corticosteroids, we have continued to seek a greater understanding of arthritic disorders and new drugs for their treatment.

One such drug—INDOCIN® (indomethacin), a nonsteroid, anti-inflammatory agent fundamentally different in structure and activity from other drugs in use—was recently made available for the treatment of arthritic conditions. It opens new possibilities for the long-term management of arthritis and inflammatory disease.

MERCK SHARP & DOHME | where today's theory is tomorrow's therapy
Division of Merck & Co., INC., West Point, Pa.

INDOCIN®

INDOMETHACIN

Indications: Chronic and acute rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout.
Contraindications: Active peptic ulcer, gastritis, regional enteritis, or ulcerative colitis. Safety in pregnancy has not been established. Not recommended for pediatric age groups.
Warning: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles, machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism.
Precautions and Adverse Reactions: Most commonly, headache, dizziness, lightheadedness, G.I. disturbances. The C.N.S. effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. Ulceration of the stomach, duodenum, or small intestine has been reported and, in a few instances, severe bleeding with perforation and death. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; INDOCIN should be discontinued if G.I. bleeding occurs. As a result of G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. Rare reports of effects not definitely known to be attributable to INDOCIN include bleeding from the sigmoid colon (either from a diverticulum or without a known previous pathologic condition), perforation of preexisting sigmoid lesions (diverticulum, carcinoma), and hematuria. In other rare cases, a diagnosis of gastritis has been made while the drug was being given. One patient developed ulcerative colitis, and another, regional ileitis, while receiving INDOCIN; when the drug was given to patients with preexisting ulcerative colitis, there was an increase in abdominal pain. Infrequently observed side effects may include drowsiness, tinnitus, mental confusion, depression and other psychic disturbances, blurred vision, stomatitis, pruritus, edema, and hypersensitivity reactions. Slight BUN elevation, usually transient, has been seen in some patients, although the preponderance of evidence indicates that INDOCIN does not adversely affect renal function, even in patients with preexisting renal disease. Nevertheless, renal function should be checked periodically in patients on long-term therapy. Leukopenia has been seen in a few patients. Transient elevations in alkaline phosphatase, cephalin-cholesterol flocculation, and thymol turbidity tests have been observed in some patients and, rarely, elevations of SGOT values; the relationship of these changes to the drug, if any, has not been established. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity.
Before prescribing or administering, read product circular with package or available on request.

Right there where he's needed



...due to LEPTINOL®

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EDITORIALS

Boldness About Baldness

"Hair loss on the scalp," writes Sauer[1] authoritatively, "is important because it is so obvious." This incisive observation is confirmed by many doctors—particularly dermatologists—to whom men come for cure of baldness. Well, there is no shortage of clinical material when it comes to alopecia. With the wonders of modern medicine, and the deep and precise physiologic diagnostic instruments now at our disposal, we should, by now, know what causes baldness. It is, we have been told, the wearing of hats. No, it is failure to wear a hat. One or the other, but we forget which. It is exposing the head to sunlight, or perhaps keeping it in the dark. No, it is lack of pantothenic acid, or maybe an endocrine defect rather than an avitaminosis. Or perhaps it is inherited like the color of one's eyes. Shampoos will cause the hair to fall out, or shampoos will stimulate the hair to grow. There is much said on both sides.

The doctor whose own scalp is well stocked may be somewhat unsympathetic to the patient who complains of baldness. After all, with so many more serious problems—medical, fiscal, and international—why worry about alopecia? The doctor pretends that his dismissal of the plight is due to lack of sentiment, when really it is due to lack of knowledge. We are, by and large, as helpless to cure it as we are to cure the common cold—or for that matter, *mal de mer.*

Perhaps it would help our less hairy brethren to know that they should be more courageous; they have no hair to stand on end. They need not the nip of the hair of the dog that bit them. They can make fun of the Beatles and quote the Biblical statement[2] that "if a man have long hair, it is a shame with him." And they remember that Shakespeare once dismissed a hirsute man as "having more hair than wit."[3] They may wear blue serge suits, for they need not fear the sprinkle of dandruff against the blue.

So let them tease. We know why they have a special bald-headed row at the more interesting shows. For Mercantini[4] assured us that "alopecia is a virility symbol in that you can't have baldness without a good supply of male sex hormones." So there———

The Pen Is Mightier

Whether it is a ball pen or an old-fashioned nib point, the pen is still the most widely used medical instrument—if you except the doctor's tongue. So it appears, from a survey made by Dr. Richard Scott as reported to the World Health Organization's Conference on Training Doctors for the Community.

Dr. Scott made a time-study of what each doctor actually did in contact with patients in his own office. These activities fell into four categories: talking, listening, writing, and manipulating. The latter included such activities as giving injections, syringing an ear, applying a dressing, suturing a laceration, and so on. Talking took up to 45 per cent of the time; listening, only 3½ per cent (which surprised many of the doctors who were sure that they spent most of their time listening); manipulating, 10 per cent; and writing, 41½ per cent. These figures are drawn from a study of what general practitioners did. Obviously, the dentist would do more manipulating and the psychiatrist (one hopes) more listening. But in general, the pen appeared to be mightier than the needle—or at least used more often.

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1. Sauer, G.C.: Skin Diseases. Philadelphia, 1959, Lippincott. Page 187.
2. I Corinthians, XI, 15.
3. In, of all places, *A Comedy of Errors.*
4. Mercantini, E. S.: *Medical Tribune,* New York, October 2, 1965. Page 18.

Most of the writing was, of course, in the form of prescriptions, but a substantial proportion referred to preparing disability and insurance certificates, and school and other reports. (Time spent dictating to or instructing secretaries was counted as writing time.) But when medical education was reviewed, it appeared that inadequate effort was devoted to this aspect of medical writing—particularly to the preparation of disability certificates.

This JOURNAL has, over the past year, published several articles* on how to prepare a disability report—but the occasions which precipitated the need for these articles were the frequently unsatisfactory reports submitted by the patient's own practitioners. Since the patient's getting the benefits (to which he is entitled) often depends on the vividness and accuracy of the reports, this would appear to be worth some serious attention.

The Non-Emergency Room

More and more people, it seems, are flocking to hospital emergency rooms for the kinds of complaints that used to send them to private medical offices. Last spring's survey by the American College of Surgeons suggested that something like 50 per cent of the cases handled in these hospital areas were not, by any definition, real emergencies. People wander in for the treatment of sore throat, seborrhea, or sunburn. *Massachusetts Physician* has estimated that one State alone spends some 3 million dollars a year for "emergency" facilities largely used for non-emergencies. South Carolina's State *Medical Journal* calculates that 30 per cent more people use emergency rooms on Saturdays than on Fridays. One possible explanation would be that some doctors, reluctant to interrupt their own weekends, encourage patients to go to hospitals on Saturdays and Sundays. The South Carolina *Journal* rejects this thesis and prefers to believe that the patient, unwillingly to lose working time, arranges to have his emergencies on weekends.

A collection of the reasons suggested in the medical literature reveals seven explanations:

(1) Fewer families have family doctors—since they go directly to specialists. So the hospital casualty room becomes their family GP office. (2) Patients and families often call police, first aid squads, or ambulances in such situations as heart attacks; and these ambulances prefer to transport their patients to hospitals, not private offices. (3) Since the public is barraged with pleas to contribute to hospital maintenance and building funds, many people assume that they are "entitled" to hospital emergency service *gratis,* and thus visit these rooms like bargain basements—to save money. (4) Television has made the hospital look like a glamorous miracle-worker, and people still want miracles. (5) Persons who have no telephones find it easier to go to a hospital than to start feeding dimes in a booth in the hope of swiftly locating a physician. (6) We are such a mobile people that every year finds thousands upon thousands of families in New Jersey alone moving to new locations—and a newcomer thinks of a hospital first when he needs medical help. (7) Some doctors even advise patients to go to hospital emergency rooms—perhaps to meet them there and use x-ray or laboratory facilities or because they (the doctors) are too busy at the moment.

Pick your own reason. But whatever the cause, the net result is to accustom the patient to institutional practice—to accept the doctor assigned rather than the one they want—and to set up the picture of the practitioner as a hard man to get.

Hospitals say that they are losing money by operating these "emergency" facilities and that, if the abuse doesn't stop, they'll need a subsidy. And from whom will the subsidy come? You guess.

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* Respiratory: May 1964, page 173
Orthopedics: February 1965, Page 60
Visual: October 1965, page 484
Psychiatry: November 1965, page 517

ORIGINAL ARTICLES

In this clear call for greater community participation by physicians, President Jehl reminds us of Medicine's number 1 public relations problem of the middle sixties.

The Road Ahead*

Joseph R. Jehl, M.D./Clifton

It is with mixed feelings that today I accept, with profound gratitude, the great honor that you bestow upon me by conferring upon me the Presidency of The Medical Society of New Jersey. I am immensely happy that you have found me worthy of your confidence and trust. I am hopeful that as the 174th president of our distinguished Society I will so serve as to merit your commendation. I am eager to address myself to the many tasks that the presidency imposes and anxious that the decisions which together we take and the actions which we plan will be the best possible for the profession and the people whom we serve. I am joyful in the appreciation of the good that has now come to me at your kind hands . . . and sad because of loved ones of family and friends who have not been spared to savor this hour with me. To all of them and all of you who have made my present position possible — from the depths of my heart — my thanks!

After these many days of protracted meetings, I do not propose to make a lengthy speech. Instead I shall but briefly note some of the considerations and problems with which we must deal in the months ahead. I realize that to enumerate them is not to dispose of them. But to recognize them accurately and to appraise them honestly is the first step.

Among the areas of pressing concern, then, I include:

The clarification and equitable stabilization of our collective and individual relations with our hospitals, our professional organizations, and our communities.

Unquestionably, great changes are taking place with reference to the relations of physicians to hospitals, and with reference to the relations of the hospitals with the provision of health care services. Within the hospitals, the status of the physician as the sole lawful purveyor of professional medical and surgical services must be constructively fortified. In this undertaking the current efforts to achieve the professional and economic emancipation of hospital-based physicians — such as the pathologist, the radiologist, the anesthesiologist, and the physiatrist — are of significant importance. Full solutions have not yet been worked out, but I think that, by dint of intelligent and searching investigation and analysis, we are moving in the right direction.

Within the hospitals and nursing homes, especially under the impact of Medicare and the pressures that overcrowding and mounting costs constantly intensify, utilization and review committees will play an increasingly important role. In this sphere of judgment physicians alone are qualified to function with authority and dependability. More responsibility means more work, it is true. Exposure to criticism, dissent, and lack of understanding are inescapable. But if physicians are to retain their fundamental rights to render all

* Inaugural address, delivered at the annual meeting in Atlantic City, May 18, 1966, by Dr. Jehl on the occasion of his installation as President of The Medical Society of New Jersey.

judgments and to determine all courses of action affecting the care and treatment of their patients — and these rights are theirs exclusively by law and reason — then we must not look to or suffer others to displace or supersede us. Others may have voice in determining how health care costs are to be met, but we of the medical profession alone will decide what the patient needs and how he is to be treated.

As the complex of agents and agencies increases in the area of health care services, we must be prepared to cooperate with ancillary professional and technical personnel, as long as they subserve and do not embarrass the good of the patient.

It is unquestionable that although medicine has not been eager to enter into intimate association with government, government has ardently sought alliance with medicine. To maintain the balance of harmonious relationship which alone can insure protection of the interests of the patient, as physicians we must participate in, and influence the thinking of, the agencies and branches of government.

I urge our members to greater interest and participation in the affairs of their local communities and agencies of government. I urge our members to greater participation as members of local boards of health, education, welfare services and planning, to name but a few. I urge mayors and members of city and town councils, as part of their responsibilities to their citizens, to see to it that physicians are named to such boards.

Every board of health, in my opinion, should have at least one member who is a practicing physician in the community, in addition to other members from associated professions. . . . For the good of all we must, as members of the profession, constructively influence the decisions and actions of government. If you have the qualifications for public office and can serve well in that capacity, then run for public office. Our country is what we make it. Those of us who are capable of making it better than it is have both an obligation and an opportunity to do so.

As a statewide community service, The Medical Society of New Jersey has proposed that the present system of local coroners give way to a statewide medical examiners' system. This is a proposal which we intend strongly to support — on the grounds of both justice and economy — for the general good.

We are working, in close cooperation, with agencies of government on such problems as narcotic addition, alcoholism, venereal disease prevention and control, anti-pollution programs — both for air and water — the control of sex offenders, and the reduction of traffic and other accidental deaths and injuries of all kinds. These problems all involve factors beyond the power of the profession of medicine to deal with unaided. Working with others, we hope to bring about the solutions which we cannot achieve alone.

Medical education must be our constant concern. We must pay particular attention to the medical schools in the state, by supporting and encouraging them to make their alumni products of New Jersey education of whom we shall be proud.

The Federal Medical Library program must be mentioned, too. This program is vast but will be implemented to improve the dissemination of medical knowledge.

Our lives under Medicare will require careful study, prayerful evaluation, and — particularly — eternal vigilance. The blueprints are already drawn and signed into law. Title XIX whose principle we urged in our desire to do good and help our less favored brothers may be a boomerang. We must keep aware of the laws and the changes which will be made in them. However, we owe it to the government which we have established to try to make this program work even if it goes contrary to our wishes. This is not a one way street. Both sides must be coordinated for mutual benefit or we must press to change the law. The problem is ours to solve. The Federal government's solution — an easy one in its view — is to socialize the profession of medicine. This may be the next step, if we fail. Not everyone will be

happy or satisfied. There are too many built in variables in the language of controlling law — such as reasonable and customary fees, and the disproportionate involvement of the general practitioners and internists as opposed to the pediatricians and obstetricians. There may be a large number of doctors engaged in administrative duties which will take many of them out of the field of patient care. Be patient. Offer constructive — not destructive criticisms. And above all remember to exercise the virtue of charity.

How we shall implement and utilize the projected regional complexes will pose a great problem. What can be done depends on what plans we formulate and execute in cooperation with the Federal and State governments. This could be a great threat to private practice. It will be our job to see that it does not so become.

Finally, I wish to mention a few things for your consideration in our own organization.

The whole mental health program — including alcoholism, mental retardation, sex offenders, narcotic control — is probably complex enough to call for the organization of a new committee or council. This suggestion has been made to and approved by the Board of Trustees. It reflects my thinking, too.

Are AMPAC and JEMPAC doing the job for which they were designed? It is reasonable for these organizations to work for both sides — both political parties? Can we exist half slave and half free? Think about it.

As I wrote and planned part of this presentation I was reading the recently published novel "Those Who Love," and I compared the problems of the new nation with the problems facing our profession.

In this brief presentation I have covered a large number of matters, some grave, some less serious, but all of enough importance to merit consideration and thought. I know we have excellent, clear-thinking, dedicated, industrious men and women in this organization who, I am sure, will help with these problems. You are to be complimented for your hard work, and I shall be happy to work with you, and to explore any of the roads and paths to further our efforts to provide for the care of the sick. To this end I promise to fulfill my duties and to meet my obligations to the best of my ability. Your problems are my deep concern. Do not ever hesitate to call. I am available and ready to do my best.

385 Clifton Avenue

Walking Can Be Dangerous

You're not immune to traffic accidents even when you're walking. Nine thousand pedestrians were killed and nearly 275,000 were injured last year in the United States, according to The Travelers' Insurance Companies. The report is based on statistics from state motor vehicle departments.

Those who cross between intersections run the biggest risk. More than 40 per cent of the fatal accidents and 32 per cent of all nonfatal mishaps involving pedestrians occurred between intersections. And, incidentally, 1400 pedestrians were killed in 1965 while walking along rural roads; nearly 21,000 more were injured on country byways.

Other leading factors involving pedestrian death and injury included crossing an intersection against the traffic signal and stepping from behind a parked vehicle. And, believe it or not, 300 persons were injured while standing on safety isles.

For a copy of this report, write to Public Information Director, Travelers' Insurance Company, 1 Tower Square, Hartford, Connecticut, and ask for *You Bet Your Life: 1965.*

Here is a proposed agenda for an "athletic injury prevention symposium."

The Prevention Of Athletic Injury*

Francis I. Tomlins, M.D./Ridgewood

The first component of an accident prevention program is *conditioning*. This falls into four phases, as follows:

1. Pre-Schedule: Calisthenic drills, running, sprints, machines, dummies, and stepped-up conditioning that toughens up the "contact points" before the first inter-squad football scrimmage.

2. Game Week: The experienced coach will carefully plan the conditioning program for his squad. This is vital for the physical safety of his players. The program during this period is "team conditioning." A coach's committee should be formed to outline the best daily game week program.

3. Out of Season: The athlete should be impressed with the fact that because the season is over, this does *not* mean his physical conditioning has terminated. It is unwise to go from strenuous conditioning to physical inactivity. Rather he should continue to be active on a lesser training schedule. This is especially true if the youth has terminated his formal athletic participation. If he expects to play the following year, it is imperative that he begin immediately to build a stronger body for the next season.

Out-of-season conditioning programs include weight lifting, calisthenics, the school's physical education programs, intra-mural sports; and participation in other varsity sports should also be worked out by the Coach's Committee.

4. Summer: To assist in the prevention of injuries (especially for the fall sports), it is necessary for the athlete to condition his body all year 'round. A program in keeping with the inter-scholastic regulations should be worked out by the coaches. This summer program will result in the athlete being physically stronger. It lessens the early muscle strains, develops the student's "wind" capability by running, and above all forestalls fatigue. Remember that a fatigued athlete is prone to injury.

Coaching And Equipment

These topics obviously run hand-in-hand. The coach should know the equipment he wants and needs. He should be in a position to obtain the very best for his athletes.

In football it is the coach's responsibility to fit each player's helmet individually, to prevent head and neck injuries. Re-conditioned or defective equipment certainly are not recommended. We urge a demonstration by the coaches showing the correct and incorrect technics for blocking, tackling, and so on. The "angles of contact" that each football player is subjected to in the performance of his assignments should be presented to the team physicians and trainers. In this way the mechanics of injury will be better understood. A demonstration by the coaches of the fitting of all protective equipment is recommended.

* This paper was read May 17, 1966 at a meeting of the New Jersey Association of School Physicians. Dr. Tomlins is chairman of the Sports, Health and Safety Committee.

Medical Supervision

Medical supervision for all sports begins with a careful pre-season medical history and a meticulous physical examination. This should be presented by an experienced team and school physician.

A campaign should be undertaken to publicize the need and extreme importance for a year-'round trainer for *all* sports to aid the coach and team physician. We suggest that panel discussions covering the different types of injuries and their prevention should be held as often as possible.

Taping

More effective preventive taping and bandaging should be encouraged by local demonstrations. The methods of taping the wrist, hands, thumb, fingers, thigh, knee, and ankle should always be presented. The use of the proper tape, pad, or bandage should be demonstrated for the different parts of the body subject to injury. For example, it is most difficult to tape a thumb with 2-inch tape when 1-inch is indicated.

Officiating

It is suggested that an official be included when a sport is being discussed in order to acquaint the physician and trainer with the rules of that sport.

Area Of Play

An attempt certainly should be made to have each school provide the best possible facilities free from defects or any other hazard that might cause an injury or infection.

Locker Rooms

The condition of the much-used locker room must not be overlooked. Are lighting, temperature, and ventilation adequate? How often are the floors cleaned? Do the showers work and produce hot and cold water? Are the toilets, wash bowls, and benches in good repair? Are the items of equipment properly cleaned; e.g. socks, supporters, shirts, etc.? Are clean towels and soap in adequate supply daily?

97 Madison Place

Four Billion For Drugs?

Recent figures on expenditures for personal consumption show that Americans spent 4½ billion dollars for drugs last year. Sounds like a lot of money, but before you say that there ought to be a law, consider that in the same year, Americans also spent:

$7 billion for grooming and personal care, mostly for barbers, toilet articles, and beauty shops. Anybody want a law on that?

$20 billion for alcohol, tobacco, and soft drinks.

$24 billion for recreation.

$40 billion for clothing and accessories.

$52 billion for transportation.

$80 billion for food.

So that 4½ billion for drugs doesn't really seem out of line, after all.

The Bureau of Labor Statistics tells us that using the 1958 figure as 100, the price of prescription drugs at retail counters is now 89.

And about that 4½ billion — remember that if drug prices had kept pace with rising prices for food and clothing, the drug bill would be 7 billion.

Microspherules of aspirin, each tiny globule enteric coated, will produce analgesia with fewer side effects than the traditional enteric coated capsule.

The Microspherule Concept of Enteric Coated Salicylates

Herman H. Tillis, M.D./East Orange

Aspirin is surely the most widely used therapeutic agent in the western world. Some 12,000 tons (that's *tons,* not grains, not pounds, but tons!) of aspirin are consumed every year in our country. This averages 5 tablets a day for every man, woman, and child in the United States. One of the prime uses of salicylates is surely for the treatment of arthritis and rheumatic diseases. And here is one of our problems: the epigastric pain that occurs so often after prolonged aspirin administration.

Many patients experience epigastric pain regularly after aspirin administration.

In a study involving 1630 patients, it was found[1] that 30 percent had experienced gastrointestinal distress after aspirin or aspirin mixtures. Indeed, direct gastroscopic examination[2] has indicated a direct damaging action of aspirin on the mucosal cells of the stomach with focal necrosis.

It has been suggested[3] that the local gastric irritation is due to insoluble salicylate crystals. Such salicylate particles have been demonstrated in the mucosal folds and in the region of the lesions.

Many enteric-coated aspirin tablets have been developed to minimize this irritation to the stomach and still achieve clinically effective plasma levels of salicylates. Recent studies[4,5] have revealed that these attempts have been largely unsuccessful, since there is considerable delay in absorption. Significant serum levels of salicylates do not appear until 6 hours after ingestion.

What we need is a kind of sustained-action medication which does not cause gastric irritation but which does produce a clinically significant plasma concentration of salicylate soon after ingestion. The new "microspherule" concept fulfills these criteria. In this dosage form,† each tiny aspirin particle is individually coated. There are approximately 2000 microspherules in each 1000 milligrams of the medication. The microspherules are then compressed into a tablet. This tablet has a deep-convex oval shape, which permits swallowing with ease. Each tablet contains 650 milligrams of aspirin.* The microspherules resist solution in gastric juice and pass readily into the small intestine, where their large surface areas enable the aspirin to be quickly dissolved and absorbed. This is evidenced in the plasma salicylate levels achieved in normal subjects. These plasma values last for 12 hours, thus achieving a sustained-action criterion. The average dosage is two tablets every 12 hours.

Materials and Methods

The purpose of this study was to determine the effectiveness and gastrointestinal tolerance of the microspherule form of sustained-release acetylsalicylic acid. The investigation was conducted in a double-blind crossover manner, and a comparison was made between

* For our senior practitioners, 650 milligrams equals 10 grains.

† Microspherules and plain aspirin of similar appearance were provided through the courtesy of Dr. D. M. Green, Grove Laboratories, St. Louis, Missouri.

the microspherule tablet and the regular tablet, each containing 650 milligrams of acetylsalicylic acid.

A total of 100 patients with the diagnosis of severe, chronic rheumatoid arthritis or osteoarthritis was observed for approximately one year. All subjects received each medication for at least three months' duration, where possible. Most were on the medication for longer periods. Dosage of each formulation was comparable; *i.e.*, the microspherule tablet was given in a dosage of two tablets every 8 to 12 hours, and the regular tablet in a dosage of one tablet every 4 to 6 hours.

Laboratory studies included serial red blood counts, hemoglobin, white blood counts, sedimentation rates, and others where indicated.

Patients ranged in age from 24 to 86 years. Only 16 of the 100 patients were male. A total of 43 patients had rheumatoid arthritis, the remainder being osteoarthritis.

Duration of symptoms ranged from less than one year to more than 25 years. At each visit, the patients were examined by the author, who has specialized for many years in rheumatology and is qualified to judge clinically the effectiveness of salicylates.

Pain and limitation of joint movements were present in 95 percent of the cases. Corticosteroids had been used previously in 43 and gold therapy in 27 per cent.

In a recent study[7] of the relationship between side effects and the administration of placebos, it was found that placebos accentuated the severity of previous symptoms and even produced entirely new symptoms. Some of these complaints included heartburn, nausea, belching, abdominal pain, dizziness, laxative effect, and stomach cramps. Therefore, to evaluate the gastrointestinal tolerance of the aspirin microspherules, patients were chosen who had no gastrointestinal symptoms prior to therapy as well as those with no intolerance to aspirin.

Results

The results were graded as follows: 1 — good; 2 — fair; and 3 — poor; according to the amelioration of pain and tenderness in the affected joints and the increase in range of motion. These tables show the results:

TABLE I.

Subjects	*Good*	*Fair*	*Poor*
100 Microspherules	81	13	6
100 Plain tablets	33	48	19

p is 0.001. Figures are percentages.

Side effects are shown in Table II.

TABLE II.

Side Effects

Microspherules		*Plain Tablets*
5	Stomach cramps or griping	11
0	Dizziness	4
7	Heartburn	21
1	Laxative effect	0
13	Nausea	30
8	Stomach pain	26

p was 0.001. Figures are percentages.

In comparison with plain aspirin tablets, the microspherule product was significantly more effective in the relief of symptoms and in reducing the incidence of gastrointestinal side effects. The results are statistically significant.

We postulate that the increased benefit from the prolonged action of the microspherule is due to three factors:

(a) Sustained 12-hour blood salicylate levels without peaks and declines of concentrations as occur with regular aspirin.

(b) Maintenance of analgesia throughout the night enables the patient to arise in the morning without experiencing the degree of stiffness which usually accompanies the disease process.

(c) Lack of gastric irritation permits the patient to take full dosage of the medication, thus achieving maximum therapeutic effects.

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109 South Munn Avenue

A broadened scope for tracheostomy is here visualized and exemplified.

Tracheostomy Today

F. Robert Haase, M.D.
Julio T. Noguera, M.D. / **Neptune City**

As initially conceived, tracheostomy was an emergency procedure to bypass oropharyngeal and laryngeal obstructions, thereby relieving a resulting hypoxia. Today the scope is far broader. Tracheostomy is now used in unconscious patients and should be done early. Its purposes are to remove stagnated secretions and the hypoxia they cause as well as the hypoxia and fatigue caused by supratrachial resistance. Meticulous care must be taken to assure the cleanliness of the tracheostomy tube as well as the aspirating equipment. The catheter should be of rubber and of such caliber as to fill two-thirds of the tracheostomy lumen when passed. The catheter should be square cut with only the hole at the tip. The tubing should be crimped at its proximal end when being passed and should not be released until it has been passed as far as possible. Effort should be made to enter each of the main bronchi separately by turning the head to one side and twisting the tubing to the other. If the secretion is inspissated, one to two dropperfuls (or more) of normal saline should be instilled before each pass. By this means, aspiration is beneficial in removing stagnated secretions. However, it is also beneficial in its stimulus to the cough reflex, thereby bringing peripherally stagnated secretion to the point of aspiration.

The relief of supratracheal resistance is obvious, following tracheostomy and aspiration, by the ease of respiration and the reduced effort required to obtain it. Care must be taken in this transition to relieve the obstruction slowly, when hypoxia has been prolonged or severe, in order to avoid sudden loss of carbon dioxide drive and possible vascular collapse.

Assistance with I P P B* may also be necessary in such cases.

In status asthmaticus, tracheostomy with I P P has been life saving in at least one of my cases. In any case in which assisted or artificial respiration may become or is necessary, the tracheostomy tube should be inserted with some type of cuff. However, the cuff can create complications. Tracheomalacia, tracheal dilatation, and stenosis[1,2,3] distal to the cuff may occur. This is best avoided[1] by deflating the cuff for five minutes every hour, if possible. In any case, the least amount of cuff inflation needed to make the I P P machine work is the best. Cases of tubal obstruction and inability to deflate the cuff have also occurred.[1,2,4] In some cases the cuff has not deflated[4] when the clamp was removed from the tube, with each reinflation merely being added to the previous ones. This condition has been attributed to kinking of the inflating tube in some cases while in at least one other[4] it resulted from clamping of the tube distal to the pilot balloon with sticking of the internal surfaces of the tube. All this may be avoided by measuring with a syringe the amount of air removed on deflating the cuff just as it is measured on inflation, making sure that the two quantities are equal. In no case should the inflating tube be clamped distal to the pilot balloon.[4]

In other cases[1] the inflated cuff has overridden the end of the tracheostomy tube and occluded it. Complete obstruction is obvious. Partial obstruction must be suspected when there is wheezing or difficulty in passing the

* Intermittent Positive Pressure Breathing. This identifies a machine which exerts air pressure through the trachea to assist breathing.

aspirating catheter. This may occur due to ballooning of the cuff over the end of the tracheostomy tube or sliding of the entire cuff over the end of the tube. The treatment is immediate deflation of the cuff and replacement with a fresh tube and snugly fitting cuff making sure that the latter resides completely within the trachea. Remove a segment of trachea at the time of the initial operation so as to avoid pushing the cuff up the tracheostomy tube when it is inserted.

Martinez[5] has created an ingenious tube and cuff which should avoid all of these difficulties. The cuff depends upon the pressure of the I P P machine for its inflation and deflates with each decrease in pressure in the tracheal tube. The cuff is also in contact over a much broader area of the trachea, thereby reducing the possibility of tracheal dilatation and stenosis.

Once the tracheostomy tube is inserted and the cuff inflated, a Bird or other I P P B apparatus is attached by means of an adaptor and regulated to the proper pressure for assistance. In addition, the Bird incorporates a means of adding humidity or bronchial dilators to the inspired air. One must not forget, however, the need for proper trachial toilet previously described.

More recently I have come across a new requirement for tracheostomy: placing a cuffed tube to prevent the aspiration of blood or secretions from above or from the tracheal wound into the tracheo-bronchial tree. The latter problem was exemplified by a necrotizing vascular condition involving the tongue, larynx, and neck. Within a period of four hours this patient went from a moderate purplish swelling of the tongue to a protruding swollen black tongue that filled the oral aperature, caused acute laryngeal obstruction and extended onto the sternum. An emergency tracheostomy was done. Here the tube was inserted by feel rather than visually since all tissues oozed a steady flow of blood accentuated by a tremendous engorgement of the thyroid and surrounding veins in the neck. Operation was carried out in the upright position since the patient could not breathe lying down. Once the tracheostomy tube was in place, the patient was made recumbent and all bleeding vessels clamped and tied. Generalized oozing was controlled by packing the wound down to the trachea with iodoform gauze. The bleeding seemed well controlled. Several hours later the patient had difficulty in breathing and died. A large clot extending into both bronchi was removed at post mortem. A cuffed tube would be of value in such a case if it could be inserted.

The former difficulty was encountered more recently when a tracheotomy was done for severe head injury with unconsciousness. This was complicated by bleeding into the pharynx and aspiration of blood. Because of this, a tracheostomy tube with cuff was inserted and inflated to prevent entrance of blood and secretions from above until they were controlled. The approach was completely successful.

Conclusion

Tracheostomy has matured into something more than an emergency procedure. It may be useful, with modifications, in a wider horizon of respiratory and peri-respiratory conditions than previously visualized.

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2100 Corlies Avenue

Of interest to obstetricians, pediatricians, dermatologists, and above all, to family doctors is this rare and not easily diagnosed congenital nevoid anomaly.

The Klippel-Trenaunay-Parkes Weber Syndrome

Report of a Case

Martin H. Wortzel, M.D./Millburn

The Klippel-Trenaunay-Parkes Weber Syndrome is a congenital nevoid anomaly of the arteriovenous system. It secondarily affects subcutaneous tissue, muscle and bone and results in developmental hypertrophy of one extremity,[1] rarely of two, or of all.[2] Symptoms are usually present at birth but may appear during the first year of life or even later. Early recognition is important in preventing complicating sequelae and in halting the progression of hypertrophy.

The symptomatic triad upon which the diagnosis has been clearly defined by Klippel and Trenaunay[5] as a congenital malformation of the arteriovenous system is characterized by:

(1) a segmentally distributed vascular nevus;
(2) varicosities at birth, or appearing during the first year of life; and
(3) hypertrophy involving all of the tissues, including the skeletal, so that the affected limb is increased in all dimensions, i.e., length, width and thickness.

The vascular nevus may be an angioma that is usually extensive, occurring as irregularly scattered patches or plaques; or as a diffuse, uninterrupted, reddish discoloration of the skin. It may be limited to a small segment of the skin[3] or may extend over the entire surface of an extremity, or even of one-half or the entire body.[4]

The vascular nevus may be a cavernous hemangioma (strawberry mark), a capillary hemangioma (*nevus flammeus*—port wine stain), or a "mixed type" of nevus. A nevus anemicus or lymphangioma is rarely involved, although elements of the latter are not infrequently present in a "mixed type" of nevus.

The cavernous hemangioma appears as a poorly-demarcated, round or flat, spongy lesion, bright red to deep purple in color. Whether localized or diffuse, it is composed of multiple dilated blood sinuses or imperfectly formed arterial, venous, and lymphatic elements appearing as bluish nodular, lobulated, polypoid, or flat elevations. When mixed with a capillary hemangioma, pigmented and verrucous changes can be noted in the surface. Thromboses may occur in the sinuses, and phleboliths may be palpated and are seen in roentgenograms. The patient frequently complains of heaviness and tiredness of the extremity, and elevating the limb reduces its size.

The capillary hemangioma appears as a flat or barely raised, well-demarcated, purplish red discoloration of the skin that sometimes blanches on pressure. Small vascular nodular outgrowths or warty excrescences may be scattered throughout the lesion. Histologic examination of a diffuse capillary hemangioma reveals a narrow superficial zone of numerous dilated capillaries with adult, flat endothelium.[6] When associated with a hard verrucous epithelial nevus, hyperkeratosis and acanthosis may be noted.[7]

Varicosities are invariably associated with the hypertrophy, and are usually present at birth

as bluish lines in the skin. With somatic growth they become progressively more dilated, multiple, and tortuous. At times, they may resemble a macular or tuberous angioma that has invaded the deep tissues to form aneurysmic sacs that, in the presence of an arteriovenous fistula, may occasionally pulsate. Manifestations of deep chronic insufficiency such as edema, stasis dermatitis, ulceration, and induration may eventually occur.

Typical patients with this syndrome are usually identified by the increased length of the affected limb, although occasionally it may be the same size as its normal companion member, and, in rare instances,[8] may even be smaller.[15] The hypertrophy usually appears early and becomes more evident with somatic growth. All tissues are affected. Roentgenograms generally show increased density of the soft tissues and thickening of the cortex of the long bones.[10] The affected limb may appear lardaceous and succulent, the skin thickened and difficult to raise in folds.

In most cases, multiple arteriovenous fistulae can be demonstrated. In some instances agenesis of the deep venous circulation,[13] an atresic iliac vein,[14,15] compression of the femoral vein by the femoral artery,[12] or other form of venous obstruction[11] has been responsible for the hypertrophy.[12] In the presence of one or more arteriovenous fistulae, oscillometric readings may be increased owing to increased pulse pressure; although in some instances, ischemia associated with loss or diminution of arterial pulsations has been observed.

Sweating and increased growth of hair, hyperemia, and edema may be present. The temperature of the skin of the affected limb is usually higher than that of its normal companion; but the classic bruit and thrill will not occur if the abnormal communications between artery and vein are small. Arteriography usually reveals multiple and extensive abnormal communications.

The following case report illustrates the characteristic features of the Klippel-Trenaunay-Parkes Weber Syndrome:

A full-term baby was delivered after a normal pregnancy and easy labor. At birth, the obstetrician noted dilated veins on the right thigh. These appeared as bluish lines. No other abnormalities were seen.

By the age of six, the veins of the right thigh had developed into clearly visible, palpable varicosities, and the right leg was one inch longer than the left. The patient had been examined by several physicians, one of whom was an orthopedic surgeon. All concurred that the vascular lesions were hemangiomata. A lift was placed in the left shoe to compensate for the difference in length of the legs. The rest of the past history was normal; the child attended school daily and participated in all physical activities.

The family history was noncontributory. The patient had one normal older brother. There were no known anomalies in the immediate or past family history.

By the age of 13, he was a well developed boy with numerous varicose veins of the right thigh and a capillary vascular nevus extending over the back of the right calf. The nevus was irregular in outline and composed of telangiectatic and hemangiectatic vessels producing a retiform appearance. It extended from below the popliteal fossa to the ankles and completely encircled the skin area of the leg. Several silver-dollar-sized yellowish verrucous lesions were present on the lateral aspect of the foot. These were firm in consistency and presented a cerebriform appearance consistent with a clinical diagnosis of epidermal nevus. The right leg was one inch longer than the left and three quarters of an inch wider in circumference in the region of the calf. The patient was forced to wear a shoe one size larger and two widths wider than that worn on the left foot. The right calf and skin were warmer to the touch, but no bruit or thrills could be felt anywhere in the leg. The remainder of the physical examination was normal.

Roentgenographic examination showed thickening of the cortex of the long bones of the right leg and foot. There was an increased amount of soft tissue in the affected limb, and several subcutaneous calcifications were noted in the region of the dermal epidermal lesions of the foot.

Arteriography revealed approximately three dozen arteriovenous fistulae distributed over the entire length of the right leg, making surgery impossible.

A section of tissue removed from the lesion on the right foot showed cornification and increased fibrosis of the subcutaneous layer.

Whether the arteriovenous fistulae develop after months or years in the hemangioma itself, or whether they are present independently as part of the congenital vascular anomaly (and thus may dilate and become enlarged at any time during life), is not certain. When present, they tend to enlarge progressively as do the sinuses and cavernous spaces of the hemangioma as well as neighboring arteries and veins. Allen, *et al*,[16] have reported that he-

mangiomata are associated with arteriovenous fistulae in fifty percent of the cases.

This syndrome should be distinguished from primary or secondary varicose veins by the extensive distribution of the dilated sinuses which do not follow the distribution of the great or small saphenous systems and by the absence of thrombophlebitis or venous obstruction antedating the enlargement of the leg and veins.

The syndrome must also be distinguished from Milroy's disease (congenital or hereditary lymphedema) and elephantiasis, which has been defined[16] as "a progressive histopathologic state characterized by a chronic inflammatory fibromatosis or hypertrophy of the hypodermal and dermal connective tissue." Widespread simple cavernous hemangiomata must also be distinguished from this syndrome. They are just the nevus without the accompanying signs.

Therapy must be individualized and the physician obtain what alleviation he can through intelligent symptomatic care. Patients with arteriovenous communications may be helped by surgery, hip, and back problems with orthopedic devices, and varicosities and tissue edema may benefit from the compression and the support of elastic hose or bandages.

A bibliographic listing of references and citations will be found in Dr. Wortzel's reprints.

116 Millburn Avenue

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal is the official organ of The Medical Society of New Jersey, published monthly under the direction of the Committee on Publication. *The Journal* is released the first week of the month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey, 08605.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of any material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted.

Contributions: Manuscripts submitted to *The Journal* must be typewritten, double-spaced on letter size (about 8¼ by 11 inch) paper, and forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not; and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal*. Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit original copies only, and are urged to keep carbon copies for reference. It is understood that material is submitted here for exclusive publication in this *Journal*.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P. O. Box 904, Trenton, New Jersey 08605

Our Society's unique advisory system has already proved its worth, as Dr. Featherston here shows.

The Medical Review and Advisory System*

Its Effect in the Settlement of Claims against Physicians

Daniel F. Featherston, M.D./Asbury Park

When The Medical Society of New Jersey established its current statewide coverage for professional liability five years ago, it adopted (on the recommendation of its carrier, the American Mutual Liability Insurance Company) a plan for providing its attorneys with expert opinion as to the validity of claims. It was the feeling of the Medical Society that the interests of the public and profession are essentially identical and that they are best served by high standards in both professional practice and responsibility on the part of persons filing claims. When a claim is filed against a physician, he may or may not have committed an error of omission or commission. Even if he has not, the consequences of treatment may have been unfortunate, as a result of circumstances beyond his control. Relatively few cases come to trial in our state in which a patient's claim is purely of nuisance value, and very few come to trial in which the physician has been clearly in error. In most states, the bulk of litigation is made up of cases in which there is a certain amount of reason for the patient to complain but not enough reason to complain to the extent that he does. If such cases are always allowed to be decided in favor of the complainant, a trend is set up which moves the climate of court opinion progressively further into unfavorable territory for the physician.

Some years ago, New Jersey courts established a mechanism for providing impartial expert medical opinion for tort cases. This mechanism was not statewide and was not always actively utilized in the jurisdictions where it *was* applicable. More recently the court system adopted a modification of that plan for more specific application to professional liability cases. This system has not yet become fully operative, although the backlog of pending applications for its use is large. It is pertinent to inquire what has been accomplished by the Medical Society's own efforts, under its Medical Review and Advisory System, which has been in operation for the past five years. During this period, the number of suits concluded against physicians insured under the Medical Society's program has steadily risen from only two cases in 1962 to 68 cases last year.†

What has happened to these 240 "concluded" suits? In 103 of them — that's 43 per cent of the closed cases — the claim was withdrawn. That left 137 "open" cases. Of these, verdict was in favor of the doctor-defendant in 41 of the 137, a ratio of 30 per cent. Then there were two litigated cases decided in favor of the plaintiff, which amounts to 1½ per cent of the 137 cases. The largest ratio was the 86 cases "settled by agreement." These accounted for 61 per cent of all the non-withdrawn cases.

* Submitted in behalf of his committee by Dr. Featherston, chairman of our State Society's Committee on Medical Defense and Insurance.

† In 1962, two suits were concluded. In 1963, the figure was 15. In 1964 it was 59; the following year the number was 96. And in the first five months of 1966, the total was 68—which is at the rate of 156 a year!

It would appear, then, that if the plaintiff has a legitimate claim, there is good reason to believe that the legitimate nature of this claim is being recognized by the Medical Review advisers to the carrier's attorneys and that the carrier is meeting these claims in a satisfactory manner. In such cases where the plaintiff has seen fit to pursue the defendant into territory where the pursuit has resulted in a verdict, experience suggests that juries and the courts have generally supported the defendants. Moreover, there is a fair chance that in cases where such a pursuit is energetically followed and a decision goes against the defendant, the amount the plaintiff may recover may be less than he would have recovered if the case had been settled. Such has been the issue in one of the two cases in which the verdict was in favor of the plaintiff.

As time goes by, the work load requested of these advisers must be expected to increase as the number of potential claims continues to rise. This will necessitate the inclusion of more physicians in this exacting type of unremunerative activity. It takes a new committee member about a year to become properly oriented toward this work. It means, too, the sacrifice of more time by those already engaged in it.

One of the most substantial results the work of these committees may have is the maintenance of proper professional standards in the community. While no physician enjoys having his professional activities surveyed and evaluated by others, it is obvious that the time has come to do this when a claim is filed against him by a patient he has treated. It is to the advantage of both contestants in such a controversy to have the matter examined by persons competent to judge the professional circumstances involved. It is also important for the public and the profession alike that this should be done. The filing of a claim against a physician ought to serve as a signal to him to examine fairly not only his professional standards of practice and their accuracy, but also to look into the quality of his personal relations with his patients and colleagues and the efficacy of his methods of keeping records and billing patients. Within your county medical society a number of your colleagues have devoted their attention to such matters in reviewing claims that have come before them. They are often in position to offer helpful suggestions relating to procedural matters which will serve as effective prophylaxis against claims. Do not hesitate to seek out and question the members of your county Medical Review and Advisory Committee. They are the kinds of colleagues who have already given abundantly of their time in the interest of the affairs of their fellow members, and they can be expected to give you whatever help they can.

601 Grand Avenue

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STATE ACTIVITIES

Trustees' Minutes

Since our last report in THE JOURNAL, the Board of Trustees has held three regular meetings. Detailed minutes of these meetings are on file with the secretary of your component society. Below is a compilation of significant actions by meeting.

June 19, 1966

A regular meeting of the Board of Trustees was held at the Executive Offices on Sunday, June 19.

Professional Liability Coverage Rates . . . Approved the recommendation of the Committee on Medical Defense and Insurance that an article be prepared for publication in THE JOURNAL to reflect the experiences of American Mutual in conjunction with the proposed changes in rates for professional liability insurance coverage (see page 423).

. . . Directed that the Committee on Medical Defense and Insurance proceed with an audit of the professional liability program, at a cost not to exceed $2,500.

Liability of Committee Members . . . Approved the following recommendation of the Committee on Medical Defense and Insurance — and directed that it be transmitted to the component societies:

That all committees composed of physicians limit their scope and function to the stipulated areas of their official concerns and restrict themselves to the issuance of recommendations only, unless specifically authorized and directed otherwise. In this conjunction, it should also be recommended that in the establishment of such physician committees every effort should be made to clearly define and delimit the precise function that the committee is to serve.

Dependents' Medical Care . . . Authorized the signing of the new contract for 1966-67.

Academy of Medicine . . . Approved the following statement of agreement between The Medical Society of New Jersey and the Academy of Medicine of New Jersey:

Whereas, the continuing education of the physician in New Jersey is a matter of the utmost importance to organized medicine in this state; and

Whereas, MSNJ and the Academy of Medicine of New Jersey have collateral aims and objectives in regard to such continuing medical education; and

Whereas, the Academy of Medicine of New Jersey has, for the past half-century, concerned itself primarily in organizing lectures, symposia, and meetings of specialty sections for this purpose; and

Whereas, in order to develop a truly statewide system of postgraduate medical education, with a minimum of duplication and wasted effort, a close liaison between the two organizations is desirable; therefore be it

RESOLVED, that steps be taken to establish a close working arrangement between the two organizations in all matters relating to medical education.

IMPLEMENTATION

1. MSNJ shall designate three members (at least one of whom shall be a Trustee of MSNJ) to serve, ex-officio, as trustees of the Academy of Medicine of New Jersey. Preferably the designees shall be fellows of the Academy. The designees shall serve for three years, but may be re-nominated to serve for one additional term.

2. A permanent liaison committee shall be established, consisting of the three trustees of the Academy designated by MSNJ and three fellows nominated by the Academy of Medicine (at least one of whom shall be a trustee of the Academy). This liaison committee shall cooperate in the activities of the Committee on Education of the Academy and the Annual Meeting Committee of MSNJ.

3. To provide joint sponsorship of both societies, no programs which are not of a purely educational nature shall be scheduled without the full knowledge of both parties to this agreement.

4. Effectively to carry out this agreement, both organizations will give publicity to the educational programs and will contribute moral, professional, and financial support to them.

Permanent Committee on Blue Cross — Blue Shield . . . Granted approval for members of MSNJ's Permanent Committee on Blue Cross and Blue Shield to accept an invitation issued by Hospital Service Plan of New Jersey (Blue Cross) to them as individuals, to serve as an advisory group (with counterparts from the New Jersey Hospital Association) on Medicare matters.

May 18, 1966

The reorganization meeting for the administrative year 1966-67 of the Board of Trustees was held in Atlantic City on Wednesday, May 18.

Chairman, 1966-67 . . . Elected Dr. Frank J. Hughes of Camden as Chairman of the Board of Trustees for 1966-67.

Secretary, 1966-67 . . . Re-elected Dr. Emanuel M. Satulsky of Elizabeth as Secretary of the Board of Trustees for 1966-67.

Finance and Budget, 1966-67 . . . Re-elected Dr. Samuel J. Lloyd of Trenton to succeed himself as the trustee-member of the Committee on Finance and Budget for a three-year term.

Salaried Personnel . . . Reappointed for 1966-67 at the salaries set forth in the adopted budget for 1966-67 all salaried personnel not under individual contract.

JOURNAL Advertising Rates . . . Approved the recommendation of the Publication Committee that a 15% "across-the-board" increase in (display) advertising rates become effective July 1 on all new business and January 1, 1967 on all business.

Advertising Policy . . . Re-affirmed the recommendation of the Publication Committee that advertising not be interspersed with editorial copy in THE JOURNAL.

AMA Annual Meeting . . . Authorized the following to represent MSNJ at the 1966 annual meeting in Chicago, with expenses paid: President, President-Elect, Executive Director, official delegates, and two alternate-delegates . . . Dr. John F. Kustrup of Trenton, first alternate, and Dr. Jerome G. Kaufman of Maplewood, second alternate.

AMA Membership Dues . . . Referred to the AMA delegates for introduction by New Jersey at the AMA meeting in June the resolution adopted by the 1966 MSNJ House f Delegates concerning AMA membership dues' increase. (See page 430.)

Membership Discrimination . . . Referred to the AMA delegates for introduction by New Jersey at the AMA annual meeting in June the resolution adopted by the MSNJ 1966 House of Delegates concerning discrimination in admission of physicians to units of organized medicine. (See page 431.)

Cancer Control . . . Directed that the following recommendation of the Cancer Control Committee adopted by the 1966 House of Delegates be called to the attention of the membership through THE JOURNAL:

That physicians and surgeons on hospital staffs encourage and utilize the hospital cancer programs, so that more programs will meet the standards of the American College of Surgeons.

Revision of Constitution and Bylaws . . . Named the following committee to carry out the directive of the 1966 House of Delegates that a special committee (appointed by the Board) study the recommended revision to the Constitution and Bylaws concerning the Procedure of Election, Chaper 5, for report to the 1967 House of Delegates:

Louis F. Albright, chairman—Chairman of Committee on the Revision of Constitution and Bylaws
Lorrimer Armstrong
George E. Barbour — Board
Joseph M. Gannon — Member of Committee
Samuel J. Lloyd — Board
Carl N. Ware

Medical Education . . . Received and noted for future implementation, as the occasion arises, the following recommendation of the Committee on Medical Education, as adopted by the 1966 House of Delegates:

That the liaison of MSNJ with the various colleges and professional groups be stated explicitly in future committee reports.

Utilization Review Committees . . . Directed that a follow-up letter of inquiry be sent to those component societies which have not yet established utilization review committees, calling attention to the following recommendation approved by the 1966 House of Delegates:

That utilization review committees be established in each county and that the names of the chairmen and other personnel be sent to this council.

Mental Health Council . . . Referred to the Committee on the Revision of Constitution and Bylaws, for proper amendment to the Bylaws (Section 4—Administrative Councils and Committees), to accommodate the following recommendation of the Committee on Mental Health, as adopted by the 1966 House of Delegates:

That the Special Committee on Mental Health be elevated to the status of an administrative council with special committees, as necessary, to deal with alcoholism, drug addiction, mental retardation, mental illness of children and adolescents, epilepsy, neurological disorders, and psychiatric disorders of the aged.

. . . Directed that the Special Committee on Mental Health be elevated, *pro-tem* (until such time as the House is in position to act on the appropriate amendment to the Bylaws at the 1966 Annual Meeting), to the status of an *ad hoc* committee reporting directly to the Board, with power equal to that of the four administrative councils already provided in the Bylaws.

Nursing Education and Recruitment . . . Referred to the Permanent Committee on Nursing Education and Recruitment the following comments of the 1966 House of Delegates dealing with the report of this committee:

That overtures be made to the Hospital Administrators' Association or the Hospital Association of the state to encourage increased nursing training facilities and standardization to ease the burden on hospitals maintaining nursing training schools, as compared with hospitals which maintain no nursing training schools.

Compensation of Physicians for Care of Subsidized Patients . . . Referred to the Council on Medical Services the following resolution adopted by the 1966 House of Delegates as a substitute resolution for Resolutions #5, #6, #12, and #18:

RESOLVED, that professional services rendered to patients whose health care costs are the responsibility of governmental or other agencies should be billed by physicians on their usual and customary fee-for-service basis; and be it further

RESOLVED, that MSNJ make public declaration of this policy by July 1966 and take whatever steps are necessary to effectuate it.

. . . Noted that the second "RESOLVED" above has already been implemented by its presentation in the House of Delegates at a session open to members of the public media.

Cooperation with Medicare . . . Referred to the Council on Medical Services, with the notation that MSNJ is cooperating already in the effective implementation of the Medicare Law, Resolution #11, as adopted by the 1966 House of Delegates:

RESOLVED, that The Medical Society of New Jersey continue its cooperation with those agencies involved in the implementation of P. L. 89-97 to the end that efficient and effective care may be provided consistent with the Principles of Ethics.

Use of Safety Lenses in Children . . . Referred to the Special Committee on the Conservation of Vision, as directed by the House of Delegates, Resolution #8, as adopted by the 1966 House:

RESOLVED, that The Medical Society of New Jersey use its good offices to endorse, recommend, and publicize the desirability of the use of safety lenses of either shatter-resistant glass or plastic for all children of school or pre-school age requiring corrective lenses.

Expansion of Medical School Facilities . . . Referred to the Committee on Medical Education Resolution #17, as adopted by the 1966 House of Delegates:

RESOLVED, that New Jersey medical schools receiving tax monies be urged to expand their enrollments; and be it further

RESOLVED, that a third medical school be planned for New Jersey; and be it further

RESOLVED, that The Medical Society of New Jersey take steps to promote this expansion of medical education in New Jersey and that a copy of this resolution be forwarded to the Governor and the legislators for implementation.

Project Hope . . . Referred for implementation to a committee appointed by the Board (Dr. Thomas C. DeCecio, Dr. Nicholas E. Bertha, Dr. Andrew C. Ruoff) Resolution #3, as adopted by the 1966 House:

RESOLVED, that The Medical Society of New Jersey use its good offices publicly to announce its endorsement and support of Project Hope; and be it further

RESOLVED, that The Medical Society of New Jersey set up a maximum of six (6) Fellowships, to be awarded on a pilot basis for one year, each carrying a stipend of $1,000 for a 60-day tour of duty aboard the S. S. Hope or her sistership, and that this should be reviewed annually; and be it further

RESOLVED, that these Fellowships be awarded by The Medical Society of New Jersey to those deserving and successful applicants who are either members of The Medical Society of New Jersey or residents in approved New Jersey hospitals who are recommended for such Fellowship by a component county medical society.

Separation of Professional Fees and Hospital Charges . . . Referred to the Council on Medical Services for implementation Resolution #15, as adopted by the 1966 House of Delegates:

RESOLVED, that MSNJ strongly urge the Medical-Surgical Plan to contact the Hospital Service Plan immediately to effect the inclusion of hospital-based professional medical services within the contracts of the Medical-Surgical Plan of New Jersey, and the exclusion of such services from the contracts of the Hospital Service Plan of New Jersey, with as little as possible inconvenience or cost to the Plans' subscribers; and be it further

RESOLVED, that the Medical-Surgical Plan cooperatively report to the Board of Trustees of MSNJ concerning its progress toward attainment of this end; and be it further

RESOLVED, that the members of the Board of Trustees and of the House of Delegates of MSNJ cooperatively make themselves available, to further the implementation of this transfer of coverage.

Health Care Planning and Administrative Groups . . . Referred to the Council on Medical Services Resolution #20, as adopted by the 1966 House of Delegates:

RESOLVED, that MSNJ urge the Governor and/or the Legislature of New Jersey to call a statewide conference of administrators, consumers, and providers of medical care . . . towards the establishment of an advisory council on overall health planning which would be responsible, initially, to the Governor and/or the Legislature, and later to whatever special overall state administrative agency or department would be created for the coordinated administration of all federal financed health care functions.

Implementing Legislation for Title XIX . . . Referred to the Council on Medical Services Resolution #21, as adopted by the 1966 House of Delegates:

RESOLVED, that MSNJ urge the Legislature of New Jersey to begin necessary preliminary studies towards early passage of enabling legislation for Title XIX, and be it further

RESOLVED, that MSNJ participate in the planning and development of said enabling legislation; and be it further

RESOLVED, that MSNJ strongly recommend the selection of Blue Shield and Blue Cross as fiscal intermediaries or administrators.

May 13, 1966

The final meeting for the administrative year 1965-66 of the Board of Trustees was held in Atlantic City on Friday evening, May 13.

Osteopathic Physicians and Selective Service . . . Noted that qualified osteopaths will be accepted by the armed services for duty with commissions as medical officers.

University City Science Center . . . Designated Dr. Louis K. Collins of Glassboro as MSNJ's representative to the Regional Advisory Group for the Delaware Valley Regional Medical Program.

Hospital-Nursing Home Project . . . Designated Dr. Matthew E. Boylan of Jersey City as MSNJ's representative at the planning conference with the New Jersey State Department of Health, the New Jersey Hospital Association, the Licensed Nursing Home Administration, and the Department of Institutions and Agencies—to conduct a short-term intensive course to prepare nursing home administrators for Medicare.

New Jersey Welfare Council . . . Designated Dr. John J. Bedrick of Bayonne as the Society's representative to the planning meeting of the New Jersey Welfare Council for the Annual Conference on Social Welfare, to be held in Atlantic City on October 18, 19, and 20.

Current State Legislation . . . Considered the following bills of medical import and approved the positions recommended by the Council on Legislation, as indicated. All bills thus marked* are identical with measures of last year, or preceding years, whose positions were the same.

S-142—To include under the scope of laws dealing with the practice of optometry any who offer and market for sale at retail to the general public spectacles or eye-glasses containing other than plano lenses. *Disapproved,* because it denies to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and discriminatory.

For this portion of the meeting, Dr. John Scillieri was present, to discuss with the Council the position of the

New Jersey Academy of Ophthalmology and Otolaryngology with reference to S-335 and S-336. The Council called Dr. Scillieri's attention to S-670 and A-671. At Dr. Scillieri's request, the Council reconsidered S-142, concerning which the Society's official position is one of "no action." After some discussion, the Council agreed to support the position of the Academy with reference to S-142, S-335, and S-336 and to *recommend* to the Board of Trustees that the Society's position be amended, as indicated.

S-233—To establish the procedure to admit and maintain non-tuberculosis patients, in a county tuberculosis hospital. *Approved*

*S-254—To forbid hypnotizing as a form of entertainment. *Approved*

S-270—To require every hospital to be equipped with an auxiliary power unit for use in periods of emergency; violation guilty as a disorderly person; effective September 1, 1966. *Approved*

S-290—To increase from $500 to $600 per year the
A-489—amount of the state competitive scholarship to institutions of higher education. *Approved*

S-325—To create a "Practicing Psychology Licensing Act." *Active Opposition,* because it invades the Medical Practice Act and assigns to unqualified lay-individuals functions which they are not licensed or qualified to fulfill by permitting them to practice psychotherapy.

In considering this bill, the Council had the benefit of the official position of the New Jersey Neuropsychiatric Association, which is "unalterably opposed to S-325 because it licenses psychologists to practice Medicine."

S-335—To include in the practice of optometry any person who prescribes or dispenses to the general public spectacles or eyeglasses containing other than plano lenses. *Disapproved,* because it denies to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and discriminatory.

S-336—To provide that any person who practices ophthalmic dispensing in violation of the act governing regulation of the practice shall be liable to a penalty of not more than $200. *Disapproved,* because it denies to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and discriminatory.

A-157—To permit dispensing of narcotic drugs with little or no addiction liability upon oral prescription order of a physician, dentist, or veterinarian. *Approved*

At its preceding meeting, the Council deferred action on this measure, pending receipt of a list of Class-B-Narcotic Drugs, to which this legislation makes reference. The Legislative Analyst submitted a list of these drugs, as contained in the Uniform Narcotic Drug Law and Regulations, Revised Statutes 24:18-1 to 24:18-49, inclusive and Revised Statutes 24:19-1 to 24:19-2, inclusive (III. Classification of Narcotic Drugs). After consideration of this list, the Council unanimously voted to *recommend* approval of this measure.

A-355—To define legal insanity as a defense to all crimes and to provide for commitment of the mentally ill. *Referred To Board Without Recommendation*

At its preceding meeting, the Council deferred action on this measure, pending study and recommendation by the Special Committee on Mental Health. At its meeting on March 2, the Committee on Mental Health considered A-355 and made the following report to the Council:

The committee agreed that it favored the intent and purpose of the bill in terms of its offering some modification of the M'Naghten Law, but is opposed to specific elements in the bill, as follows:

1. At least one of the "qualified physicians" obliged to attest to the "mental illness" of a defendant should be a psychiatrist — since the term "qualified" does not specify special knowledge in this field.

2. Defendants certified to be "mentally ill" should not be committed to the Diagnostic Center, since this facility was not designed, constructed, or staffed for this purpose.

3. If the court finds a defendant so affected as to require the mandated examination, then the examination referred to in the legislation should be done immediately, and not be delayed for as long as 60 days — as permitted in this legislation. This is pertinent to the issue, since the health of many people can be impaired during the 60 days interval.

The Council could not support item (1) above, because it was of the opinion that mental illness is not the exclusive concern of psychiatrists.

The Council could not support item (2) above because — under existing law — diagnostic centers *are* specifically designed, constructed, and staffed to deal with persons certified to be "mentally ill."

The Council could not support item (3) above, because it is an assumption by the committee that is not substantiated by the language of the legislation.

After much discussion, the Council — by individual motion and vote — failed to arrive at a position concerning this bill. Motions were duly made, seconded, and *lost* in an attempt to recommend positions of approval, disapproval, or no action.

The legislation, therefore, is referred to the Board without recommendation.

After discussing this legislation in detail, the Board *deferred action,* pending further investigation and evaluation by other qualified medical and legal authorities.

*A-393—To create the New Jersey Hazardous Substances Labeling Act. *Approved*

A-425—To repeal the law granting immunity to nonprofit charitable institutions from actions for damages for injury to persons. *Disapproved,* because the Society supported S-204 of 1958, which created the law A-425 seeks to repeal.

*A-475—To prohibit subrogation of hospital and medical service or any insurance company for any hospital or medical services. *Disapproved,* in support of the position of MSP.

A-507—To require fingerprinting and photographing of persons arrested for any offense relating to dangerous drugs. *Approved*

A-547—To supplement and amend various portions of the Uniform Narcotic Drug Law. *Approved*

A-548—To supplement and amend various portions of the statute concerning regulation and control of the handling, sale, and distribution of depressant and stimulant drugs. *Approved*

*A-556—To provide that any impairment of health of firemen or policemen caused by hypertension, heart disease or tuberculosis shall be presumed to have been received in the performance of duty. *Disapproved,* because it involves diagnosis by legislative enactment rather than by medical investigation.

A-592—To provide that no accident or health insurance policy shall terminate coverage of a dependent at age 19 where the dependent is incapable of self-support which is provided by the policy holder and where incapacity is by reason of mental retardation or physical handicap attained before age 19 and where notice is submitted. *No Action*

A-593—To provide that no hospital service corporation shall terminate coverage of a dependent at age 19 where the dependent is incapable of self-support which is provided by the policy holder and where incapacity is by reason of mental retardation or physical handicap attained prior to age 19 and where notice is submitted; to permit exclusion of such persons from coverage. *No Action*

A-594—To provide that no medical service corporation shall terminate coverage of a dependent at age 19 where the dependent is incapable of self-support which is provided by the policy holder and where incapacity is by reason of mental retardation or physical handicap attained prior to age 19 and where notice is submitted; to permit exclusion of such persons from coverage. *No Action*

The Executive Director reported that he had been in touch with Medical-Surgical Plan and Hospital Service Plan concerning Assembly Bills 592, 593, and 594. It was their opinion that Society could safely take a position of "no action" on these measures.

A-617—To prohibit persons from placing, turning, or draining or placing where it can run, flow, wash or be emptied into any of the fresh tidal waters within the state any deleterious or poisonous substances of any kind. *Approved*

A-620—To prohibit persons from placing, turning, or draining or placing where it can run, flow, wash or be emptied into the Delaware River above or below Trenton falls any explosive deleterious or poisonous substances. *Approved*

A-648—To correct several technical errors in the mental retardation act. *Action Deferred,* pending receipt of copy of the bill.

A-670—To require every board of education to employ an optometrist. *Disapproved, With Active Opposition If Bill Moves,* because the school physician already has the obligation to screen for physical defects— including impairment of vision. The addition of an optometrist would, in consequence, be an unjustifiable and expensive redundancy.

A-671—To require the state and its subdivisions to accept reports and testimony of any licensed optometrist; to prohibit discrimination between licensed ocular practitioners and to prohibit interference with any individual's free choice of ocular practitioners. *No Action*

AMA Dues Increase . . . Noted the expressed opposition of eight component societies to an AMA dues increase; approved the following resolution for presentation to the 1966 House of Delegates, for consideration and action:

WHEREAS, the American Medical Association has requested an increase of $25.00 per annum in membership dues, as necessary for the maintenance of its operation; and

WHEREAS, eight of the twenty-one component societies of The Medical Society of New Jersey have recorded opposition to that proposed increase; and

WHEREAS, it is greatly feared that such increase in dues will result in a marked decrease in AMA membership; and

WHEREAS, such relevant financial figures as are available indicate a progressive expansion of American Medical Association activities and a constant increase of expenditures — from $12 million in 1958 to $28 million in 1966; and

WHEREAS, in consequence, the American Medical Association contends that its operating reserve has been reduced to a dangerously low level; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of the New Jersey record itself as disapproving the proposed $25.00 increase in AMA membership dues, and that it recommend to the House of Delegates of the American Medical Association, that, in lieu of the proposed increase, it vote a special membership assessment of $10.00 per capita for one year, to be earmarked exclusively for the replenishment of the operating reserve; and be it further

RESOLVED, that no withdrawal from that operating reserve be permitted except by explicit action of the AMA House of Delegates; and be it further

RESOLVED, that the American Medical Association be called upon forthwith to re-examine all its activities for the purpose of reducing expenditures in all but essential and proper areas.

Academy of Medicine of New Jersey . . . Noted the appointment by the Academy of Medicine of the following committee to explore closer liaison and cooperation with MSNJ:

Morris H. Saffron, M.D.
W. Austin Tansey, M.D.
W. Franklin Klein, M.D.
Victor Parsonnet, M.D.
Stewart F. Alexander, M.D. (alternate)

MSP . . . Noted with appreciation a formal resolution from the Board of Trustees of Medical-Surgical Plan of New Jersey, commemorating the Society's 200th anniversary.

Membership Discrimination . . . Studied the several resolutions from component societies (to the 1966 House) concerning admission of physicians to units of organized medicine; approved the following resolution for consideration by the 1966 House, to accomplish the purpose of the related resolutions:

WHEREAS, The Medical Society of New Jersey has, since 1870, held as its undeviating policy that "Race, color, and creed are no barrier to membership, and that certified competence and character should be the only criteria for membership in any scientific body."; and

WHEREAS, it is alleged that membership in the American Medical Association is being denied by virtue of discriminatory practices at county and state levels; and

WHEREAS, there is no American Medical Association mechanism of appeal of which a rejected applicant at county and/or state level can avail himself; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey recommend to the House of Delegates of the American Medical Association that such changes in the Constitution and Bylaws of the American Medical Association as are necessary be effected to assign to the American Medical Association Judicial Council the right and responsibility to receive and act upon appeals filed by applicants who allege that they have been unfairly denied membership in county and/or state medical societies.

Joseph P. Donnelly, M.D. . . . Expressed, with a standing ovation, the appreciation of the Board to Dr. Donnelly, who—under MSNJ's Bylaws—is ineligible for re-election to the Board of Trustees.

Cooperation With Bar Association

Throughout New Jersey—and in many adjacent states, too—interest has been aroused in the agreement developed between the Morris County Medical Society and the local Bar Association. Here is the full text:

WHEREAS, the members of the Morris County Bar Association and the Morris County Medical Society recognize that problems of co-operation between the medical and legal profession have arisen as a result of the increase in litigation involving personal injuries, and further recognize that medical-legal co-operation is necessary in order to maintain the proper attitudes of mutual respect of each of these learned professions for the other; and

WHEREAS, the Morris County Bar Association and the Morris County Medical Society have appointed their respective committees to study the aforesaid problems; and

WHEREAS, said committees propose the following agreement as a proper one to be entered into by these professional associations and as one which will further the interests of those persons who are served by both professions;

NOW, THEREFORE, BE IT AGREED:

ARTICLE I
Medical Reports

1. Physician's Duties.

A. To provide adequate information to the attorney requesting the same concerning the patient, including results of examination, diagnosis, tests, prognosis, and up-to-date bill for services rendered.

B. To supply such a report within a reasonable time after the same is requested.

C. To provide supplemental reports when any significant change occurs in the patient's condition or when requested by the attorney after a reasonable length of time has expired following a prior report.

2. Attorney's Duties.

A. To compensate promptly the physician for the report if said compensation is requested and to provide such compensation in advance if the physician so requests. The sum of TEN DOLLARS ($10.00) to TWENTY-FIVE DOLLARS ($25.00) is agreed to be a reasonable fee for such report, in the ordinary case, the amount dependent upon the time consumed in preparation of the reports and the specialized knowledge transmitted therein. It is agreed that the physician may request a sum in excess of TWENTY-FIVE DOLLARS ($25.00) in an extraordinary case justifying such a fee.

B. To provide the physician with an authorization signed by the patient permitting the physician to divulge the requested information to the attorney.

ARTICLE II

Conferences between the Attorney and the Physician

1. It is agreed that it is mutually advantageous for the physician and attorney to confer in reference to a particular case prior to the time of trial.

2. Such conferences should be arranged at the physician's office, and arrangements should be made a sufficient time in advance of the trial so that the conference can be fitted in the schedule of the attorney and the physician. The physician should bill the attorney for the conference at the same rate which he would charge for treating a patient for a similar period of time. This bill should be paid promptly by the attorney and should not be contingent upon the success of the suit.

ARTICLE III
Court Testimony

1. Both parties recognize that there is a necessity for the dissemination of information to both professions concerning the time problems involved in court testimony. The Medical Society recognizes that the legal

profession faces calendar problems, which include the uncertainty of dates in a fluid trial calendar. The Bar Association likewise recognizes that the physician's appointments are made in advance and that physicians are, in addition, faced with pressing medical problems which cannot be deferred.

2. Attorney's Duties.

A. The attorney should ascertain whether the physician will be available during a trial term prior to the calendar call for that term.

B. The attorney should write to the physician immediately following the calendar call to advise the physician of the proposed trial date.

C. The attorney should keep the physician's office advised of the status of the calendar and should telephone the physician's office on the day prior to the proposed trial date to advise of the likelihood of whether the case will be reached.

D. Physicians should be kept "on call" and should be given at least one hour's notice of the time when they will be required to appear at the Court House. Physician should not be asked to appear until attorney is reasonably certain that he will not have to remain at the Court House more than a short period of time before being allowed to testify. When physician enters Court Room, he shall, through a court attendant, make his presence known to the attorney trying the case. Attorney shall endeavor to put the physician on the stand as soon as possible after his arrival in the Court Room subject to orderly and proper presentation of the case.

E. In the event of settlement, the physician should be immediately notified of the fact that the case is settled so that his schedule is not interfered with to an excessive extent.

F. The attorney should not use a subpoena to secure the attendance of a physician in court unless the physician refuses to abide by the terms of this Agreement and the client's case would be prejudiced thereby.

G. The physician should be promptly compensated for his appearance as an expert witness. No such compensation should be contingent upon the outcome of the litigation. It is agreed by all parties that a reasonable charge for court testimony by a physician is SEVENTY-FIVE DOLLARS ($75.00) to ONE HUNDRED FIFTY DOLLARS ($150.00), except that lesser or greater charges may be reasonable in an extraordinary case requiring special research or absorbing extraordinary amounts of a physician's time.

3. Physician's Duties.

A. The physician has an obligation to give testimony regarding his patient in court. If the physician undertakes the care of a patient and litigation ensues, the physician is duty bound to testify as to medical condition of that patient, subject to the provisions of this Agreement.

B. When given adequate notice of the time at which he will be called upon to testify, the physician should make himself available at that time, unless an emergency situation arises which precludes his appearance.

ARTICLE IV

Depositions at the Physician's Office

1. Fees and arrangements for oral depositions should be the same as set forth in Article III above for court testimony.

ARTICLE V

Preparation of Affidavit or Certified Statement on Settlement in Infant's Case

1. Physicians recognize that the Rules of Court provide that a physician's statement or affidavit may be submitted in lieu of his testimony in any case in which a settlement of an infant's claim is presented to the court for approval.

2. Whenever possible, the attorney should complete the statement from information previously submitted to him by the physician. Where such information is not sufficient, the treating physician will supply sufficient information for the completion of the statement.

3. The physician should execute such statement or affidavit promptly after his receipt of the same.

4. If the physician has received a fee for the submission of his reports previous to the execution of the statement, there should be no further charge for the execution of the statement or affidavit. If no charge has been made at the time of submission of the statement, the physician is entitled to make a charge for the same in accordance with the Schedule set forth in Article I above.

ARTICLE VI

Physician's Outstanding Bill to His Patient For Medical Services Rendered

1. It is suggested that every attorney include in his retainer the following sentence: "I authorize my attorney to pay all my medical bills, including hospital, nurses, doctors and the like, on my behalf, in the event of a recovery or a settlement from my share of the recovery." In the event that such a phrase appears in the written retainer, it is the attorney's duty to ascertain the amount of the doctor's bill and to see to the payment of the same out of any recovery, whether by verdict or settlement, irrespective of whether a lien has been filed.

2. In the event of a dispute between patient and physician as to amount of bill, attorney representing plaintiff shall not take part in either side of the dispute and shall retain entire amount claimed by physician in his trust account until controversy is settled or disposed of, provided the phrase contained in paragraph 1 above is in a written retainer.

3. In the event that a patient has failed to pay his bill, the physician is entitled to demand from the patient an assignment of that part of any judgment or recovery which he may receive which will be sufficient to pay the physician's bill. The physician may demand such an assignment as a condition precedent to supplying any reports or appearing for expert testimony.

ARTICLE VII

Sanctions

1. The Medical-Legal Co-operation Committee, composed of three members of each of these associations, shall sit as a permanent committee.

2. Any physician or attorney aggrieved with the conduct of a member of the other profession in relation to a matter arising under or related to the terms of this Agreement may make a complaint in writing to said committee by forwarding a letter detailing the nature of the complaint to either of the co-chairmen of this joint committee.

3. Upon receipt of such a complaint, the chairman of said committee shall notify its members of a meeting of the same within ten days.

4. Said committee shall inquire into the merits of the complaint and may request further information from either of the parties involved. Said committee may then attempt to negotiate and arbitrate the dispute.

5. If the dispute cannot be arbitrated in a manner satisfactory to all parties concerned, this committee may, by majority vote, issue its opinion passing upon the conduct involved as proper or improper, as the case may be, and may further make a recommendation for censure to the trustees of the Morris County Bar Association in the event an attorney's conduct is disapproved, or to the executive committee of the Morris County Medical Association if a physician's conduct is disapproved.

6. The trustees of the Bar Association or the executive committee of the Medical Association may then issue a statement of censure to the party involved, if such action is merited.

ARTICLE VIII
Social Relations

1. It is agreed that both societies shall endeavor to hold a joint social meeting at least once a year to foster and improve personal relationships between the two professions.

2. Both societies agree that they will expend efforts to explore further areas of co-operation between them, including the offering of seminars, lectures, etc., which will be instructive to the members of either or both societies.

The Third Century Begins*

Chronologically the oldest state medical society in the United States, The Medical Society of New Jersey was founded on July 23, 1766, at a meeting held in New Brunswick. The 17 physicians who signed the "instrument of association" that day met in response to a notice which read: "A large body of the practitioners in physic and surgery in New Jersey, having agreed to form a society for the advancement of their profession and the promotion of public good, request and invite every gentleman of the profession in the province to attend a meeting at Mr. Duff's Tavern in the city of New Brunswick on Wednesday, July 23, at which time and place, the Constitution and Regulations of the Society are to be settled and subscribed."

The group elected as its first president the Rev. Robert McKean, pastor and physician, Rector of St. Peter's Episcopal Church in Perth Amboy.

The Society met semi-annually until its activities were temporarily disrupted, in 1775, by the Revolutionary War; it held a "southern" meeting at Burlington and a "northern" meeting at New Brunswick or Princeton.

During the Revolution, one-half of the members served with Washington's forces. The Society's fourth president, Dr. Nathaniel Scudder, was killed in action. Dr. William Burnet, the Society's second president, and Dr. John Cochran, its third president, became the surgeons-general of the Eastern and Middle Departments of the American Army. Only one month after Yorktown, in 1781, the members reassembled to resume professional activities.

The venerable seal used to identify the Society dates from 1786 and depicts the oracle in the Temple of Apollo, the god of healing. A priest is shown delivering a prophesy. Above him shines the light of inspiration. The Latin inscription, *Opiferque per orbem dicor,* is from the *Metamorphoses* by Ovid. This is translated, "I am called the help-bringer throughout the world."

District and county medical societies were authorized in 1816, due to increases in Society membership and the general population. At present, there are 21 county component medical societies.

In 1819, we took part in the establishment of the first U.S. Pharmacopeia. The State Legislature, in 1825, granted our Society the right to award the degree Doctor of Medicine. This legal sanction, used until early in the present century, has never been revoked.

By 1837 the Society was emphasizing the need for a state hospital for the mentally ill; its reports led to the founding at Trenton, in 1848, of the first state psychiatric hospital in this country. Also in 1848, a year after we had

* Fred B. Rogers, M.D., Historian-Archivist of The Medical Society of New Jersey.

participated in the founding of the American Medical Association in Philadelphia, the *New Jersey Medical Reporter* appeared and was made an official medium for quarterly publication of the society's activities. In 1859 the Society established its own annual publication, the *Transactions,* which was succeeded (in 1904) by the monthly *Journal of The Medical Society of New Jersey.*

The end of the nineteenth century, and the early years of the present one, were a period of expansion, centralization, and standardization in America.

The Medical Society of New Jersey, in 1903, adopted a new constitution to modernize its position in the national organization. Military service in World Wars I and II, and in Korea, again called members to the service of their nation. In 1938, the Society became a pioneer in developing prepaid health insurance and hospitalization plans. Keeping abreast of current professional advances and social factors affecting medical practice, The Medical Society of New Jersey — now looking forward to its third century — is proud of its heritage and optimistic about its future.

New Jersey recently marked the site of MSNJ's founding in New Brunswick. A commemorative plaque at the northeast corner of Albany and Peace Streets (near the Raritan River bridge) states: "The Medical Society of New Jersey — oldest state medical organization in the nation — was founded here, at Duff's Inn, in 1766."

Publication of *The Healing Art,* a comprehensive one-volume history of The Medical Society of New Jersey, documents two centuries of professional and cultural progress in the Garden State. Carefully prepared by the Society's archivist-historian Fred B. Rogers, M.D. and A. Reasoner Sayre, this chronicle provides a readable and factual record of the pioneer organization. A 400-page book with 75 illustrations, its art work was done by Homer Hill, eminent New Jersey artist. An attractive, accurate compilation, the volume is the product of several years of research and will be an authoritative reference for years to come.

The title page of the original minute book of The Medical Society of New Jersey, preserved at The New Jersey Historical Society in Newark, bears the following quotation from the Harveian Oration for 1748 by Dr. Richard Mead (1673-1754) to the Royal College of Physicians of London:

Amant, enim societatem Scientiae; et Concordia, tanquam communi anima, vigent. [They love therefore the fellowship of science; and they thrive through concord as well as common spirit.]

Citation To Mr. Nevin



The Academy of Medicine of New Jersey has presented a special Citation to our Executive Director, Richard I. Nevin. The Citation reads as follows:

The Academy of Medicine of New Jersey
presents this
Special Citation
to
Richard I. Nevin
Executive Director of the Oldest Medical Society in the United States

in recognition of devoted and untiring service rendered over a period of many years to the medical profession of our State. On the felicitous occasion of
The 200th Anniversary
of
The Medical Society of New Jersey

Presentation was made at the annual "Awards Dinner" at the Academy on June 1.

1966–1967

Committees and Councils

AMA Delegates

C. Byron Blaisdell, M.D. (1968) ..... Asbury Park
Joseph P. Donnelly, M.D. (1967) ..... Jersey City
Marcus H. Greifinger, M.D. (1968) ..... Newark
Frank J. Hughes, M.D. (1968) ..... Gloucester
Jesse McCall, M.D. (1967) ..... Newton
Luke A. Mulligan, M.D. (1968) ..... Leonia
Isaac N. Patterson, M.D. (1967) ..... Westville

AMA Alternate Delegates

Matthew E. Boylan, M.D. (1968) ..... Jersey City
F. Clyde Bowers, M.D. (1968) ..... Mendham
Jerome G. Kaufman, M.D. (1968) ..... Maplewood
John F. Kustrup, M.D. (1968) ..... Trenton
Joseph R. Jehl, M.D. (1967) ..... Clifton
Robert E. Verdon, M.D. (1967) ..... Cliffside Park
Louis S. Wegryn, M.D. (1967) ..... Elizabeth

Delegates to Other States

Delegates

New York—Joseph P. Donnelly, M.D. (1967)
Jersey City
Connecticut—Lloyd A. Hamilton, M.D. (1967)
Lambertville

Alternates

New York—David B. Scanlan, M.D. (1967) .. Ventnor
Connecticut—Frank W. Konzelmann, M.D. (1967)
Somers Point

STANDING COMMITTEES

Annual Meeting

Jerome G. Kaufman, M.D., *Chairman*
(1968) ..... Maplewood
Edward E. P. Seidman, M.D., *Vice Chairman*
(1967) ..... Plainfield
Milton Ackerman, M.D. (1969) ..... Atlantic City
George J. Kohut, M.D. (1968) ..... Perth Amboy
Peter H. Marvel, M.D. (1967) ..... Northfield
Robert E. Verdon, M.D. (1969) ..... Cliffside Park
Marcus H. Greifinger, M.D., *Secretary*
Ex-Officio ..... Newark

*Scientific Exhibits

Milton Ackerman, M.D., *Chairman* (1967) Atlantic City
Arthur Bernstein, M.D. (1967) ..... Maplewood
Thomas K. Rathmell, M.D. (1967) ..... Trenton
James A. Rogers, M.D. (1967) ..... Paterson
John J. Thompson, M.D. (1967) ..... Caldwell
Robert E. Verdon, M.D. (1967) ..... Cliffside Park

*Scientific Program

George J. Kohut, M.D., *Chairman* (1967) Perth Amboy
Chairmen and Secretaries of Scientific Sections, as listed below:

Allergy

Roslyn Barbash, M.D., *Chairman* ..... Teaneck
William Greenberg, M.D., *Secretary* .... Perth Amboy

Anesthesiology

Francis G. Casey, Jr., M.D., *Chairman* .. N. Plainfield
Dexter B. Blake, M.D., *Secretary* ..... Morristown

Cardiovascular Diseases

Gilbert E. Levinson, M.D., *Chairman* ..... Jersey City
Theodore H. Goldberg, M.D., *Secretary* .... Westwood

Chest Diseases

Alfred Yager, M.D., *Chairman* ..... West New York
David Wiener, M.D., *Secretary* ..... Irvington

Clinical Pathology

Jacques B. Wallach, M.D., *Chairman* ..... Westfield
Simon Soumerai, M.D., *Secretary* ..... Camden

Dermatology

Hugh McCulloch, Jr., M.D., *Chairman* .... Plainfield
Harry C. Goldberg, M.D., *Secretary* ..... Plainfield

Gastroenterology and Proctology

Robert Horowitz, M.D., *Chairman* ..... Jersey City
Salvatore J. Detrano, M.D., *Secretary* .... Union City

General Practice

Victor H. Boogdanian, M.D., *Chairman* New Brunswick
Carl A. Restivo, M.D., *Secretary* ..... Jersey City

Medicine

Milton Cutler, M.D., *Chairman* ..... Atlantic City
Jacob L. Drossner, M.D., *Secretary* ..... Pennsauken

Metabolism

Henry A. Terwedow, M.D., *Chairman* .. North Bergen
Harvey P. Einhorn, M.D., *Secretary* ... South Orange

Obstetrics and Gynecology

James L. Breen, M.D., *Chairman* ..... Newark
Paul Andreson, M.D., *Secretary* ..... Elizabeth

Ophthalmology

Oram R. Kline, Jr., M.D., *Chairman* ..... Camden
Humbert M. Gambacorta, M.D., *Secretary* .... Newark

Orthopedic Surgery

Robert G. Greene, M.D., *Chairman* ..... Montclair
John J. Reilly, Jr., M.D., *Secretary* ..... Elizabeth

Otolaryngology

August P. Ciell, M.D., *Chairman* ..... Haddonfield
James E. Brennan, M.D., *Secretary* ..... Camden

Pediatrics

Suzanne A. Widrow, M.D., *Chairman* ..... Hanover
Louis L. Krafchik, M.D., *Secretary* ... New Brunswick

Psychiatry and Neurology

Bernard R. Goldberg, M.D., *Chairman* .. East Orange
Joseph C. Borrus, M.D., *Secretary* ... New Brunswick

Radiology

John R. Helff, M.D., *Chairman* ..... New Brunswick
Richard Kirchner, M.D., *Secretary* .. New Brunswick

Rheumatism

Peter W. Vanace, M.D., *Chairman* ..... Haddonfield
William D. Kimler, M.D., *Secretary* .... Collingswood

Surgery

Adolph R. Wichman, M.D., *Chairman* ..... Denville
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John B. Fuhrmann, M.D. (1968) ..... Flemington
Peter J. Guthorn, M.D. (1969) ..... Neptune
Marion F. Kaletkowski, M.D. (1967) ..... Clifton
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William J. Roe, M.D. (1967) ..... Englewood
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Edward E. P. Seidmon, M.D. (1967) ..... Plainfield
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William I. Weiss, M.D. (1967) ..... Livingston

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William E. Bray, M.D. (1967) ..... Pemberton
George L. Erdman, M.D. (1967) ..... Summit
Roy T. Forsberg, M.D. (1967) ..... Westfield
Warren H. Knauer, M.D. (1967) ..... Elizabeth
Bernard Koven, M.D. (1967) ..... Englewood
Stephen M. Liana, M.D. (1967) ..... Paterson
Sylvan E. Moolten, M.D. (1967) ..... Highland Park

Child Health

Dorothy K. Klughaupt, M.D., *Chairman* (1967) Passaic
Neil Castaldo, M.D. (1967) ..... Cranford
William J. Farley, M.D. (1967) ..... Nutley
Robert E. Jennings, M.D. (1967) ..... So. Orange
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Bernard N. Millner, M.D. (1967) ..... Trenton
Eli Rubenstein, M.D. (1967) ..... Bayonne
Sydney Tucker, M.D. (1967) ..... Perth Amboy
Charles O. Tyler, M.D. (1967) ..... Haddonfield

Conservation of Vision

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Samuel M. Diskan, M.D. (1967) ..... Atlantic City
Joseph H. Kler, M.D. (1967) ..... New Brunswick
Oram R. Kline, M.D. (1967) ..... Camden
James P. Morrill, M.D. (1967) ..... Paterson
Robert E. Murto, M.D. (1967) ..... Trenton
Ralph E. Siegel, M.D. (1967) ..... Perth Amboy
D. Blair Sulouff, M.D. (1967) ..... Morristown
Anthony M. Sellitto, M.D. (1967) *Consultant* ..... South Orange

Maternal and Infant Welfare

John D. Preece, M.D., *Chairman* (1967) ..... Trenton
Mary Bacon, M.D. (1967) ..... Bridgeton
Robert A. Cosgrove, M.D. (1967) ..... Jersey City
Frederick J. Faux, M.D. (1967) ..... Woodbury
Edward Foord, M.D. (1967) ..... Burlington
Theodore K. Graham, M.D. (1967) ..... Paterson
Dominic A. Introcaso, M.D. (1967) ..... Clark
Herbert F. Johnson, M.D. (1967) ..... Camden
Arthur C. Kragen, M.D. (1967) ..... East Orange
Frank L. Paret, M.D. (1967) ..... New Brunswick
Daniel B. Roth, M.D. (1967) ..... Teaneck
Francis U. Seiler, M.D. (1967) ..... Trenton
Curtis F. Culp, M.D., *Director*, Division of Constructive Health, New Jersey Department of Health *Consultant* ..... Trenton

Mental Health

Edward A. Schauer, M.D., *Chairman* (1967) ..... Farmingdale
Joseph C. Borrus, M.D. (1967) ..... New Brunswick
David I. Canavan, M.D. (1967) ..... Oakland
Paul C. Fagan, M.D. (1967) ..... Bloomfield
Francesco A. Figurelli, M.D. (1967) ..... Jersey City
Robert S. Garber, M.D. (1967) ..... Belle Mead
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Evelyn P. Ivey, M.D. (1967) ..... Morristown
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Martin H. Weinberg, M.D. (1967) .. P.O. Hammonton

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Jack R. Karel, M.D., *Chairman* (1967) ..... Hillside
R. Winfield Betts, M.D. (1967) ..... Medford
William A. Dwyer, Jr., M.D. (1967) ..... Paterson
Albert Ehrlich, M.D. (1967) ..... Fort Lee
Sidney Ketyer, M.D. (1967) ..... South Orange
Francis J. Mara, M.D. (1967) ..... Manasquan
Frank L. Paret, M.D. (1967) ..... New Brunswick
Lynn A. Parry, M.D. (1967) ..... Asbury Park
Frank R. Schell, M.D. (1967) ..... Butler
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Medicine and Religion

Jerome G. Kaufman, M.D., *Chairman* (1967) ..... Maplewood
Charles H. Calvin, M.D. (1967) ..... Perth Amboy
John S. Madara, M.D. (1967) ..... Salem
Thomas H. McGlade, M.D. (1967) ..... Camden
Luke A. Mulligan, M.D. (1967) ..... Leonia

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Nicholas E. Marchione, M.D., *Chairman* (1967) ..... Vineland
Albert F. Moriconi, M.D. (1967) ..... Trenton
Raphael E. Remondelli, M.D. (1967) ..... Belleville
Herbert W. Weisman, M.D. (1967) ..... Bayonne

Traffic Safety

William L. Sprout, M.D., *Chairman* (1967) ..... Salem
R. Winfield Betts, M.D. (1967) ..... Medford
Albert Ehrlich, M.D. (1967) ..... Fort Lee
Martin D. Meyerson, M.D. (1967) ..... Edison
Edward A. Schauer, M.D. (1967) ..... Farmingdale
Harry F. Suter, M.D. (1967) ..... Penns Grove
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OBITUARIES

Dr. Scipio H. Africano

On May 29, 1966 death came to Dr. Scipio H. Africano, a Hudson County radiologist. Born in Italy in 1902, he had lived in Union City since the age of 4. He earned a B.S. at Rutgers in 1923 and an M.D. at Bellevue four years later. After an internship at Montclair's Mountainside Hospital, he returned to Union City to practice. He was an early diplomate of the American Board of Radiology, active in the Hudson County Medical Society, and senior attending radiologist at the North Hudson Hospital.

Dr. Sol Gurshman

At the early age of 59, Dr. Sol Gurshman died on May 26, 1966. He was the 1964 winner of the "General Practitioner of the Year" plaque presented by the New Jersey Academy of General Practice. A native of Brooklyn, he received his M.D. at New York Medical College in 1932. He came to New Jersey to intern at the Perth Amboy General Hospital; and except for his Army service, he worked the rest of his life in our Middlesex County. He spent the four years of World War II in the Pacific, the last year in Okinawa. Dr. Gurshman was active in civic organizational affairs throughout the Raritan valley. He was president of the county's Heart Association, school physician for Metuchen, a long-term member of his town's Board of Education, and a dynamic member of several committees of his hospital staff and his county medical society. He was senior attending in medicine at Perth Amboy Hospital at the time of his death there.

Dr. Herman Kaplan

Herman Kaplan died as, perhaps, most doctors want to die: he died with his shoes on while taking care of a patient. On June 15, 1966, he was doing a caesarean at the North Hudson Hospital in Weehauken when he fell to the floor. The assisting surgeon finished the procedure. Dr. Kaplan was born in 1903, earned his M.D. at Bellevue in 1929. He interned at the North Hudson Hospital, then did graduate work in gynecology and obstetrics at the New York Lying-In Hospital. He then took a residency in that specialty at the Jersey City Medical Center.

In addition to an active gynecologic and obstetrical practice in Hudson County, Dr. Kaplan was a leader in the field of public education. He was president of the Weehawken Board of Education, president of the North Hudson Physicians Guild, and president of the North Hudson Jewish Community Center.

Dr. George Edward Legg

At the untimely age of 53, Dr. George E. Legg of Brielle died on the first day of summer, 1966. A native of Paterson, he received his baccalaureate degree at Muhlenberg College and his M.D. at Hahnemann in 1941. He returned to his native city to intern at the Paterson General Hospital, and then established a private practice in Monmouth County. He was a general practitioner, with special interest in surgery, and a Fellow of the International College of Surgeons. He was active in our Monmouth County component society.

Dr. George P. Meyer

A half century of medical practice came to a close on May 7, 1966 with the death that day of Dr. George P. Meyer of Camden. Born in 1895, he received his M.D. at Jefferson in 1916. Serving in the Medical Corps of the Army in World War I, he returned to Camden and did graduate work in ophthalmology. He eventually became president of the New Jersey Ophthalmologic Society and chief of ophthalmology at Our Lady of Lourdes Hospital in Camden. He earned an AOA membership while at Jefferson and was an early diplomate of the American Board of Ophthalmology.

Dr. John F. Moriarty

Dr. John Francis Moriarty, a prominent Hudson County surgeon, died on May 26, 1966. Born in Massachusetts in 1897, he was one of the small elite group of Naval Aviation cadets during World War I. Then in 1920 he entered the Jefferson Medical College, from which he received his M.D. in 1924. Dr. Moriarty was active in the American Association of Railway Surgeons, having for many decades served as a surgeon to the Erie Railroad. He was an attending surgeon at St. Francis Hospital in Jersey City and an Associate Surgeon at the North Hudson Hospital. He had several tours of duty as president of the medical staff at St. Francis Hospital.

Dr. Helen F. Schrack

One of New Jersey's leading women physicians — and a past president of our State's Women's Medical Association—Helen Frances Schrack, died on June 19, 1966 at the age of 73. A 1923 graduate of Women's Medical College, she was active in the Camden County Medical Society since she entered private practice in 1925. Some years ago, Dr. Schrack was the laureate of the Elizabeth Blackwell Association award to the "outstanding woman physician in the United States." She served as the first Publication Chairman of the American Medical Women's Association, and was generally considered responsible for the launching of the well known journal of that association. She was historian for the Camden County Medical Society for many years and edited the history of that society recently issued in connection with its centennial.

Dr. Herman Shlionsky

One of New Jersey's pioneer psychoanalysts, Dr. Herman Shlionsky, died on June 1, 1966 at the age of 62. Dr. Shlionsky earned his B.A. along with a Phi Beta Kappa key at New York's City College in 1924, and his M.D. at Yale in 1928. After interning at Grace New Haven Hospital, he took a residency at Boston Psychopathic Hospital and came to New Jersey in 1937 to head up the mental hygiene clinic network for the County of Essex. He then entered formal analytic training, becoming eventually a training analyst himself for the New York Psychoanalytic Institute. He was a founder and first President of the New Jersey Psychoanalytic Society, and an active member of the psychiatric staff at Mountainside Hospital. During World War II, he was a lieutenant colonel in our Army's medical corps.

Dr. Morton M. Stern

Morton Stern died as most of us want to die: with our shoes on, at work, and taking care of a patient. He had a cerebral hemorrhage at his office desk. He was only 51 at the time of his death on April 26, 1966. Born in Newark, he earned his M.D. degree at Tulane in 1938. After finishing his internship at the Newark City Hospital, he became a psychiatric resident at Greystone Park, and then was accepted for an additional residency at the New York Psychiatric Institute. He supplemented this with a neurologic residency at Montefiore. He served in the medical corps during World War II and then entered private practice. He was a Board Diplomate, chief of psychiatry at Newark City Hospital, and on the staff of several other hospitals.

Dr. William S. Voorhies

One of Ocean County's senior practitioners died on June 19, 1966, with the passing that day of William Sinclair Voorhies, M.D. Born in Trenton in 1893, he received his M.D. degree at the University of Vermont in 1919. He took a residency in neurology at New York's Graduate Hospital in 1921 — one of the first physicians to enter that program. He then entered private practice in Mendham, serving as a consultant at Greystone Park. He then moved to Ocean County, assuming senior responsibilities at the staff of Pinehaven in Bayville. He maintained a private practice in Point Pleasant.

ANNOUNCEMENTS

Psychiatry for all Physicians

Temple University announces two courses in psychiatry for all physicians. Courses in office psychiatry, for which the American Academy of General Practice grants 30 hours of credit, will be held in the Psychiatric Department Lecture Room of Temple University in Philadelphia Wednesday mornings, starting October 26, for ten consecutive Wednesdays. Registration fee is $30.

A course in basic psychosomatics will cover 20 mornings, starting with Wednesday, October 5, and terminating with the session on February 22, 1967. This program runs from 10 A.M. to 3 P.M., and free luncheons are included. Registration fee is $40, and the American Academy of General Practice grants 80 hours of credit.

For further information and registration, write to Dr. H. Keith Fischer, Director, 5450 Wissahickon Avenue, A-110, Philadelphia, Pennsylvania 19144.

Chemotherapy Conference

Ocober 26, 27, and 28 are the dates of the next Interscience Conference on Antimicrobial Agents. The meeting will be at the Sheraton Hotel in Philadelphia starting at 9 A.M. October 26. For more details, write to American Society for Microbiology, P.O. Box 265, Princeton, New Jersey 08540.

Nutrition In Sickness

Philadelphia's highly successful annual conference on nutrition and metabolism will be held this year on November 2 at the County Medical Society's building, 2100 Spring Garden Street. Attention will focus on nutritional problems associated with internal diseases, with convalescence and with surgery. For more details, write to Dr. Milton Perloff, 2923 Cheltenham Avenue, Philadelphia.

Obstetrics and Gynecology Course

An intensive 3½ day course in gynecology and obstetrics will be held November 16 through 19 at the St. Barnabas Medical Center in Livingston, N.J. Tuition will be $12 a day or $35 for the entire program. The latter fee includes parking and luncheons. Doctors coming from a distance will be able to find accommodations at a nearby motel. For more details, write to Dr. James Breen, Section on Obstetrics, Academy of Medicine, 315 Belleville Avenue, Bloomfield, N.J. 07003.

Cryo-Ophthalmology

Interested in the application of low temperature technics to the eye? If so, become a charter member of the American Society of Cryo-ophthalmology. Details are available from Dr. John G. Bellows, 30 North Michigan Avenue, Chicago 60602.

Course in Gastroenterology

Announcement is made of an intensive graduate course in gastroenterology to be given at the Bellevue Stratford in Philadelphia on October 27, 28, and 29. For further information, write to the American College of Gastroenterology, 33 West 60th Street, New York 10023.

Careers in the Mental Health Field

A new Public Affairs pamphlet on careers in the mental health field is available to your interested patients and their families for the sum of 25¢. The pamphlet is published by the Public Affairs Committee, 381 Park Avenue, South, New York 10016.

Army Looking for Women Physicians

Women physicians are now eligible for regular Army commissions with all of the benefits,

laws, and regulations pertaining to pay, promotion, and retirement. The grades range from Captain to Lieutenant Colonel, depending upon age, experience, and professional qualifications. The minimum period of active duty is two years. For more details write to the Surgeon General, Technical Liaison Division of the Army, Washington, D.C. 20315.

Handbook on Care of Incontinents

A concise handbook on the home care of the incontinent patient is now available for free distribution to your patients and their families. You may obtain a copy by writing to Johnson and Johnson, at New Brunswick 08903. The name is "Home Care and the Incontinent Patient," prepared by Maxine Hartman, R.N. Brochures will not be sent directly to patients or families, but only through a physician.

Conference on Sports Medicine

On November 27 this year, the Eighth AMA-sponsored colloquium on sports medicine will be held in Las Vegas, Nevada, at Caesar's Palace. (What better place?) The theme will be medical service to school and college athletic programs. Included will be special forums on knee injuries, physical fitness, and medical preparation of athletes. For more details, write to Committee on Medical Facets of Sports, AMA, 535 North Dearborn Street, Chicago 60610.

Feminine Psychology

Doctors who have been mystified by feminine psychology now have an opportunity to participate in an intensive and extensive course in the subject. This starts on October 19 at the VA Hospital in East Orange and is under the aegis of the department of psychiatry of the New Jersey College of Medicine. The teacher is Natalie Shainess, M.D., a distinguished New York psychiatrist. Sessions are at 10:30 a.m. on eight consecutive Wednesdays. Tuition fee is $50 for the eight weeks. For registration and more details, write to Dr. Morton Kurland, 76 Woodland Avenue, West Orange.

New New Jersey ACP Fellows

The American College of Physicians bestowed FACP honors at the 47th Annual Session last May. Our Garden State roster of new Fellows of the ACP included: Dr. Norman N. Kohn of Cinnaminson; Dr. Robert Nutt of Englewood; Dr. Myra R. Zinke of Holmdel; Dr. Thomas C. Rommer and Dr. Emil Neibart, both of Irvington; Dr. John J. Calabro and Dr. Duncan Hutchson, both of Jersey City; Dr. John F. Stockfisch of Long Branch; Dr. Martin H. Wortzel of Millburn; Dr. James Kent Young of Mt. Holly; Dr. Samuel C. Bukantz of Nutley; Dr. Maurice F. Deraney of Ridgewood Dr. Milton Singer of Short Hills; Drs. James Robinson and Robert B. Francis, both of Summit; Dr. William P. McCarthy of Trenton; Dr. Arthur J. Perelman of Union; Dr. Elliott Middleton, Jr. of Upper Montclair; and Dr. Max Braitman of West New York.

Radiation and Isotope Seminar

An *Institute on Therapeutic Radiation, Radium and Radioisotopes for Physicians* will be presented on Saturday, November 19, 1966, from 9:00 a.m. to 12:30 p.m. at St. Barnabas Medical Center, Livingston, N.J. This is sponsored by the Academy of Medicine, the New Jersey Commission on Radiation Protection, and the State Department of Health. The seminar will emphasize medical radiation safety practices, substitution of newer radiation sources, and details of New Jersey regulations covering medical use of radium, radioisotopes, and radiation generating machines. Material to be covered will include therapeutic x-ray dosimetry; radium and radioisotope uses in radiology, urology, and dermatology; radiation reactions; hazards involved; radiation therapy substitutes for radium and intercavitary and surface therapy; New Jersey regulations governing the use and possession of radium and other radioactive materials.

Reservations may be made by writing to Samuel C. Ingraham, M.D., Radium Research Project, State Department of Health, 11

Washington Street, West Orange, New Jersey; or by telephoning 201 OR 5-8700.

Perinatal Mortality

At the convenient hour of 4:30 p.m., on Thursday, September 29, a symposium on perinatal mortality will be held at the Somerset Hospital in Somerville. Sponsored by the Academy of Medicine of New Jersey, the colloquium will be headed by a panel of distinguished experts. The chairman, A. L. Katcher, M.D., is director of pediatrics at the Hunterdon Medical Center, Flemington, New Jersey. A detailed program may be obtained from Dr. Katcher.

Post-Hospital Planning

An all-day seminar on post-hospital planning is scheduled for the Mountainside Hospital in Montclair on Wednesday, September 28. In addition to formal presentations on "The Dynamics of Post-Hospital Care," the program includes special workshops on female alcoholics, coronary patients, and unmarried mothers. For details, write to Mrs. Iris Muhlenthaler, Outpatient Department, Mountainside Hospital, Montclair, New Jersey.

Legislation on Child Abuse

New Jersey is one of the 47 states with laws on reporting of child abuse. Practically all these laws protect physicians who in good faith report such cases—protect the doctor against suits for defamation of character, civil suits for libel, and criminal actions. However, the statutes are complicated, and there is much variation in the definition of "child," the extent of the immunity granted, special provisions about malnutrition, and so on. These statutes have been compactly and clearly summarized in a pamphlet called *Child Abuse Legislation* prepared by the American Humane Association, based on a study largely underwritten by the American Legion Foundation. For a copy of the brochure, write to American Humane Association, Box 1266, Denver, Colorado 82021.

The Measurement of Depression

Lakeside Laboratories at 1707 North Avenue, Milwaukee, Wisconsin, 53201, will, at your request, send you a scale for the rating of depression. This consists of 20 statements, phrased in lay language, which pick up evidences of depression. The pad includes a scoring key. There is no charge for one of the pads. Also available, through Lakeside Laboratories, is a 22-minute sound and color (16 millimeter) film for presentation to medical groups.

Erratum

On page 331 of the August (Transactions) issue of THE JOURNAL, the footnote identifies the Committee on Chronically Ill and the Aging and the Committee on Occupational Health, Rehabilitation, and Workmen's Compensation as "Special Committees to the Council on Public Health." The footnote should have identified them as "Special Committees to the Council on Medical Services."

LETTER TO THE JOURNAL

The Right to Life

Dear Sir:

Last year, a major TV network devoted an hour of prime time to abortion laws in the United States. Most of the experts favored a liberalization of the statutes. Arguments in favor of such a position might be summarized as follows:

1. Illegal abortions are widespread. Estimates run as

high as five million *per annum* in the United States alone.

2. These abortions, done under clandestine circumstances, are fraught with danger to the mother. On the other hand, under proper hospital conditions, they are relatively safe and easy.

3. Physicians are hampered by archaic laws from doing these procedures when they know they are to the best interest of the mother.

4. No individual must be made to suffer permanently merely because she conceived an unwanted child.

5. Those babies that may be victims of malformations are better off dead.

The above statements, while they are freighted with emotional impact, will not stand the light of close scrutiny. The argument that illegal operations are widespread is, I submit, no argument at all—for so are rape, murder, and burglary. And abortions done under the most rigid conditions and with full hospital sanctions are hazardous. The experience of the Scandinavian countries demonstrates that the prospective patient may finally lose not only her pregnancy, but her uterus as well—indeed, her life.

The third and fourth arguments ignore every right that the unborn child may have. In most communities, facilities exist for unwed mothers, even for children of families who cannot support them. If it is a disgrace for a married mother to place her newborn child for adoption, at least it does not result in the death of that child for the sake of a dollar bill.

Lastly, the arguments for aborting malformed children: No physician or board of physicians can state with medical certainty that this particular child will be malformed, no matter how serious or adverse the circumstances incidental to the prenatal environment. For example, if we were to abort all women who contracted rubella in the first trimester of pregnancy, two out of three of these operations would be done on normal children. It would seem far more logical to develop an effective vaccine against rubella (a project presently under development) and then to make it mandatory that all female children be immunized against the virus.

To say that malformed children are better off dead is to endorse the theory of the super race.

Picture this scene: A group of physicians, presumably the "Abortion Board," would announce to the expectant mother that, after due consultation, she was a candidate for a therapeutic abortion. "After all, mother, you do not wish to bring a monstrosity into the world." Once establish this precedent, and where do we stop . . . it may be the thalidomide victim today, and all children with an I.Q. below 120 a generation hence.

As a practicing physician, it seems to me that the kernel of this problem rests with the definition of what exactly constitutes a human being. For if humanity does not exist at the time of conception, when does it occur? Various legal authorities have placed it at the point of viability, or at birth. Neither answer will suffice. Actually, the point of viability depends on the state of medical knowledge and not on any inherent defect in the gestating fetus itself. Just as artificial kidneys became a reality, and artificial hearts a near reality, so artificial wombs are in the foreseeable future. Thus it may be perfectly feasible to remove a fetus, say at four months, and place this newborn child within an artificial uterus and allow it to develop to term.

As to the argument that a baby is not a human being until birth, not even the most ardent advocates of abortion will say that Birth is merely the process of separating the fetus from the mother; it adds or detracts nothing intrinsically from the fetus itself. Thus we are faced again with the conclusion that humanity exists from the time of conception. To be sure, it is difficult to equate a fertilized ovum with a fully mature human. Do we say: "Since it does not look like one of us, it cannot be one of us"?

We have here reached the ultimate in human prejudice. Not content with denying our fellowman a place in the sun because of his color, we now wish to deny him the most basic right of all—that is, to life.

D. A. Introcaso, M.D.
Clark, N. J.

BOOK REVIEWS

Gastroenterology. By Henry L. Bockus. Volume 3, Ed. 2. Philadelphia, 1965, W. B. Saunders Co. Pp. 1352, illustrated. ($30.00)

This third and final volume of the complete text on Gastroenterology by Bockus and forty-four other contributors is a complete text on diseases of the liver, biliary tract, and pancreas, with a thorough discussion of gastro-intestinal parasitology. Also included in this volume are secondary infections of the gastro-intestinal tract dealing specifically with psychiatric aspects of gastro-intestinal disease, functional disorders, gastro-intestinal allergy. The interrelationship of the cardio-vascular and gastro-intestinal disorders is discussed.

In the thorough discussion of the various topics there is adequate presentation of the anatomy, physiology, disease processes, and treatment.

Illustrations are clear, and the bibliography of all sections is extensive.

The discussion of so many aspects of conditions of the various organs by many authors leads to some duplication, but this really leads to ease of reading.

This edition will be the leading reference in this field for many years to come. GEORGE FEY STOLL, M.D.

Symposium on the Lens. Edited by John E. Harris, M.D. St. Louis, 1965, Mosby. Pp. 381. Profusely illustrated. ($18.50)

Here a well presented and illustrated historical perspective introduces the reader to the study of the lens from the operations first performed to the discovery of the true position and function of the lens. The description of cataract extraction by Celsus and others is an amusing addition. Experimental reports here show the influence of the lens on the cornea and vitreous, and indirectly the choroid and sclera. Illustrations of the various phases have depended upon the electron microscope as a most valuable instrument responsible for much of the presented material.

Cytologic studies on lens epithelium showing a comparison of the effects of x-rays, Myleran, and TEM are presented in detail as well as cellular proliferation in the lens. However it is not the intent of this text to describe pathology in detail unless it serves a purpose primarily intended by the participators. The final chapters consider the metabolism of the lens as related to energy transport, aging, and experimental cataractogenesis. A discussion on sugar metabolism and cataracts allows participants to comment on their differing views about the role of sugar metabolism and cataract formation.

Ophthalmologists, physiologists, and laboratory workers concerned with the anatomy, biochemistry, physiology, and immunology of the lens will find this a valuable reference source. The clinician (out of touch with specific research of the lens) will find much of the material too complex. HOWARD M. EISENSTODT, M.D.

New Drugs: 1966. American Medical Association, Chicago. Pp. 584. ($4.00)

Packed into one thick, soft-backed volume you will find monographs on the almost 300 single-entity products that have been marketed in our country since 1956. Each monograph gives information on the drug's actions and adverse reactions; contraindications, precautions; dosage, routes of administration, preparations and their sizes and strengths. This gives you an assessment of the more recently introduced drugs. The evaluations will be of immediate assistance to the physician in his day-to-day practice. Since a monograph on a drug is included whether or not the Council's opinion is favorable, *New Drugs* is in no sense a list of approved or accepted drugs. Drugs are indexed by their nonproprietary (generic) and trade names.

Here is your road-map through the new drug jungle!
VICTOR HUBERMAN, M.D.

Surgery of the Biliary Passages and the Pancreas. Walter Hess, M.D. Princeton, N. J., 1965, Van Nostrand. Pp. 638, illustrated. ($25.00)

One of the most complete treatises on the surgery of the biliary passages and pancreas that has appeared in some time is this book by the Professor of Surgery at the University of Basle, Switzerland. It was translated from the German by Heinrich Lamn, M.D., F.A.C.S., of Harlingen, Texas. Outstanding operative drawings were done by Ingrid Schaumberg. This text begins with a discussion of the surgical anatomy and physiology of the biliary system and the pancreas. It includes a complete report of the many diseases of both systems, presented in a clear, concise manner enriched by the personal experience and results of the author.

Diagnostic technics and their interpretation of the various diagnoses is followed by a report on the intraoperative diagnostic procedures by radiomanometry, pancreotography, and choledochostromy, with manometric and operative phlebography of the portal vein. The several operative technics are reported in sixteen chapters with a special section on interventions for portal hypertension. The operative tactics of the various procedures are given with personal experience and clearness. Pre and post operative care of the conditions is carefully outlined. Dr. Hess then reviews complications with hepatic coma and hepatal-renal syndrome. He discusses post-operative management problems related to water, electrolyte, and protein metabolism.

This distinguished monograph is a valuable addition to any library. It is a truly up-to-date discussion of a most important surgical area.
DANIEL F. FEATHERSTON, M.D.

Gonadotropins: Physicochemical and Immunological Properties. Edited by G. E. W. Wolstenholme, O.B.E. and Julie Knight, B.A. Boston, 1965, Little Brown and Company. Pp. 125 with 28 illustrations. ($3.50)

Here you will find a wealth of material on the current status of the physicochemical and immunologic properties of gonadotropins. Much of it is highly technical, since this is a group of papers presented before a small number of experts in the field of research in gonadotropins. Each paper is discussed by other experts. This method brings out the latest knowledge in these fields

and promotes ideas for further investigation. Some of the subjects covered are the preparation of human FSH, purification of chorionic gonadotropin, problems of investigation of immunological properties of FSH, inactivation of LH by urea, and heterogeneity of gonadotropins.

The editor has produced a small and concise summary of interesting, but at times very technical, material. It should be very useful to those interested in experimental work with gonadotropins.

F. Leland Rose, M.D.

Psychotherapy and the Behavior Sciences. L. R. Wolberg, M.D. New York, 1966, Grune and Stratton. Pp. 196. ($6.75)

Within a compass of less than 200 pages, Wolberg shows how an individual's social and psychological transactions must be associated with his physiologic mechanisms and anatomic limitations. While emotional and psychological motivation obviously play a role in personality development—and in therapy—these motivational forces cannot be disembodied. From enzyme reactions to spiritual promptings, man exhibits a beautifully integrated mechanism subject to the laws of nature.

The author takes us from the single cell, through the anatomic substrates and physiologic and biochemical operations of the nervous system, through genetic factors, and into the area of cultural components. Here he includes anthropologic and sociologic forces, Wolberg discusses cybernetic, group dynamics, information theories, and religion. He suggests that psychotherapy must be influenced by all these methodologies. This vividly written, thought-provoking volume reminds us that anyone without medical training should not try to tamper with this complex, organically, and chemically rooted mechanism. And one *with* medical training should approach it with humbleness.

Herbert Boehm, M.D.

ESP: A Scientific Evaluation. By C. E. Hansel. New York, 1966, Scribners. Pp. 263. ($6.95)

The parapsychologists cite some eight or ten experiments which, they say, were error-proof and which establish the existence of clairvoyance or telepathy. In this book, the British psychologist Hansel patiently examines these crucial experiments and shows how the results could have been established without ESP. Mostly, he implies, there was fraud; or, at best, honest and negligent error.

Hansel's operating formula is that "if the result could have been arisen through a trick, the experiment must be considered unsatisfactory proof of ESP, even if it is *not* decided that any trick was used." This is, perhaps, an unreasonable guideline. If a headache improves after the patient takes aspirin, you might work out some other explanation for the relief of pain. Must you say, therefore, that the anodyne value of aspirin is unproved?

In a sense, you can't ever prove "non-existence"—so neither Professor Hansel, nor anyone else, can prove that ESP doesn't exist. But he does argue that no parapsychologist has ever set up an experiment with better-than-chance results that could not be explained by modalities other than ESP.

Parapsychologists are fond of quoting statistics on the order of: "The possibility that this score could be due to chance was a million to one." This sounds impressive, but in any automobile accident, the chances—the day before—that this particular car would be at the same place as that other car at precisely the same time—this would have been a possibility in this million-to-one order. Indeed, if in a run of 25 Zener cards, the percipient can call 8 of them right, this is considered a phenomenally good result. (Something other than chance must be operating, insists the parapsychologist.) But in our profession, if a drug failed 17 times out of 25, it wouldn't be said that the experiment proved that the drug was an effective one.

This is a solid little book that will interest the agnostic and support the skeptic; but probably not convert the faithful.

William S. Schram, M.D.

Sexual Behavior in the Human Female. Alfred C. Kinsey, Wardell B. Pomeroy, Clyde E. Martin, Paul H. Gebhard. New York, 1965, Pocket Books, Inc. Pp. 863. ($1.65) Paperback.

This pocket-book is a completely re-set, but verbatim, copy of the original W. B. Saunders edition of the 1953 Kinsey Report. The widely publicized wealth of data on all phases of sexuality are herein documented and discussed. The basis for the book is an analysis of contributions by almost 8,000 females, and covers pre-adolescent sexual development through marital experiences, homosexuality, and a comparison of male and female. If you want an addition to your library, here is an inexpensive way of obtaining a great deal of factual material. For those who have not seen the original Kinsey, this edition is recommended for informational value.

Laura E. Morrow, M.D.

Colour Vision. Edited by A. V. S. de Reuck, M.Sc. and Julie Knight, B.A. Boston, 1965, Little, Brown and Company. Pp. 382, illustrated. ($12.50)

This weighty and scholarly book represents a symposium on color vision, the participants of which were eminent physiologists, biologists, psychologists, and biophysicists. The result is pure scientific presentations and discussions, most of which are, alas, quite above the capacity of the average ophthalmologist.

The quantity and the quality of the work done is most impressive and fascinating. The investigation of the nature and behavior of visual pigment in various species of fish; the type of pigment in relation to their aquatic environment; the structure of the retina of various animals as seen with the electron microscope; the duality of retinal cells as derived from epithelial cells — such subjects are dealt with in great detail. The Young-Helmholtz theory in relation to the actual photo-receptors is dealt with and delicate experiments described such as the use of suprafine micro-electrodes inserted to a single cone of a fish retina. Blue, red, and green receptors are found and described.

The final chapters have to do with color vision in animals (cats are not really color blind and honey bees distinguish color quite well!) and in humans as well as the genetics of color blindness. This book is truly for those who are students of color vision and who are interested in the cellular mechanisms involved.

S. Jerome Greenfield, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

SEPTEMBER, 1966 • VOL. XXXIX, NO. 7

In a rare occurrence, thirty persons developed erythema multiforme or erythema nodosum or both during an outbreak of histoplasmosis in a town in Iowa. The skin lesions preceded clinical manifestations in some patients, appeared after onset of histoplasmosis in others.

ERYTHEMATOUS LESIONS AS CLINICAL MANIFESTATIONS OF HISTOPLASMOSIS

In 1962 an epidemic of histoplasmosis occurred in Mason City, Iowa. The source of the infection was a starling roost in the center of town, and the epidemic resulted when heavy equipment was used to remove trees and underbrush from the contaminated area. In 1964 a second attempt to clear the site led to a second epidemic of histoplasmosis in the same city.

During the second outbreak acute pulmonary histoplasmosis developed in 87 persons, and erythema multiforme or erythema nodosum in 30. The evidence is that the skin lesions were related to primary infection with *Histoplasma capsulatum*.

Mason City has a population of 30,642 and is located in the prosperous farmlands of north central Iowa.

Investigation six months after the first outbreak revealed that 28 persons had had clinical histoplasmosis, but no cases of erythema multiforme or erythema nodosum were reported. When there was additional work at the site of the starling roost two years later, an increase occurred in the number of cases of histoplasmosis. Furthermore, an unusual number of cases erythema multiforme and erythema nodosum appeared.

In a survey undertaken by the Kansas City Field Station of the Communicable Disease Center of the Public Health Service, skin and serologic tests and chest x-rays were made of school children, factory workers, and employees of downtown stores.

The patients with erythema lesions were examined and interviewed. The lesions were classified as erythmea multiforme or erythema nodosum or both. Biopsies of both types of lesions in one patient demonstrated tissue reactions consistent with erythema multiforme and erythema nodosum.

Appearance of Rash

Pulmonary histoplasmosis developed in 81 persons between February 10 and March 11, 1964, and six other cases occurred later. *H. capsulatum* was cultured from lung biopsies of two patients. Among the 30 persons with erythema multiforme, erythema nodosum, or a combination of both rashes were 18 patients who had had clinical histoplasmosis prior to the rash; in the other 12 there had been no symptoms before the skin rash appeared.

The clinical illness that preceded the onset of rash was typical of acute pulmonary histoplasmosis. It was characterized by a sudden onset, influenza-like symptoms, and prolonged convalescence. The most frequent complaints were fever, chills, myalgia, pleuritic chest pain, headache, night sweats, excessive fatigue, and dry, hacking cough. The period from onset of clinical disease to rash ranged from two to 42 days, with a median of 10 days.

Antone A. Medeiros, M.D.; Sophocles D. Marty, M.D.; Fred E. Tosh, M.D.; and Tom D. Y. Chin, M.D. *New England Journal of Medicine*, February 24, 1966.

The lesions of erythema multiforme varied in configuration and size, ranging from a few millimeters to 5 cm. in diameter. Most of the lesions were purplish-red, elevated plaques, frequently having a depressed slate-blue center. The erythema-nodosum lesions consisted of subcutaneous, tender, reddish-brown, warm nodules, ranging from 0.5 cm. to 2.0 cm. in diameter.

All 29 of the 30 patients skin tested for histoplasma were positive; the one patient not teste dhad a positive serologic reaction. Only one patient was positive to tuberculin.

Background of Residents

The majority of patients were lifetime residents of Iowa, and none had lived for more than six months in an area of high endemic prevalence for histoplasmosis. All had visited the downtown shopping area during the clearing of the starling roost in February, 1964.

The 1964 epidemic in Mason City is the first outbreak of histoplasmosis associated with erythema multiforme and erythema nodosum in which a point source has been clearly established. Among the evidence that the cause of the skin lesions was *H. capsulatum* was that in 18 persons the onset of rash was preceded by pulmonary histoplasmosis; of 12 persons whose first complaint was the rash, 11 were skin tested and all were positive, and seven had positive complement-fixation titers or x-ray evidence of pneumonitis as an indication of recent infection.

The fact that erythema was observed only during the second outbreak might suggest that it was related to exogenous reinfection. However, the residence histories of the patients indicated the opposite. More than half the patients with skin lesions were living in non-endemic areas outside the city during the first epidemic, and the remainder resided in areas along the periphery of town, away from the contaminated site.

It is probable that the patients with erythema nodosum and multiforme were not infected during the first epidemic and were susceptible to primary infection when they went shopping in the area in February, 1964. Among 102 employees of downtown stores, 95 per cent were positive to histoplasmin in April, 1964.

Among the persons most likely to have been reinfected — those residing near the site during both outbreaks — there were no known cases of erythema.

Skin Lesions Rare

The question arises why skin lesions due to histoplasmosis have not been reported more often from endemic areas. An answer may be approached by calculation of a case-to-infection ratio. In a survey of 2,160 Mason City school children after the first epidemic, 29 per cent were positive to histoplasmin. A survey after the second epidemic showed that 49 per cent of 1,499 children were positive.

If adults comprise two thirds of the population of the city (20,000 persons) and 15 per cent were histoplasmin sensitive before the outbreak, then 17,000 adults were histoplasmin negative. By applying the skin-sensitive rates in school children to adults, it can be seen that 5,000 adults were infected in 1962, and 6,000 adults in 1964. Erythema multiforme and erythema nodosum occurred in 16 residents, or a ratio of about three cases per 1,000 primary infections in adults.

If, as has been estimated, 500,000 new histoplasmosis infections occur annually in the United States, of which approximately 50,000 may be in adults, then approximately 150 cases of erythema lesions due to histoplasmosis occur in adults in the United States annually. Thus, it is not surprising that the association between histoplasmosis and skin lesions is frequently overlooked.

New Jersey Tuberculosis and Health Association

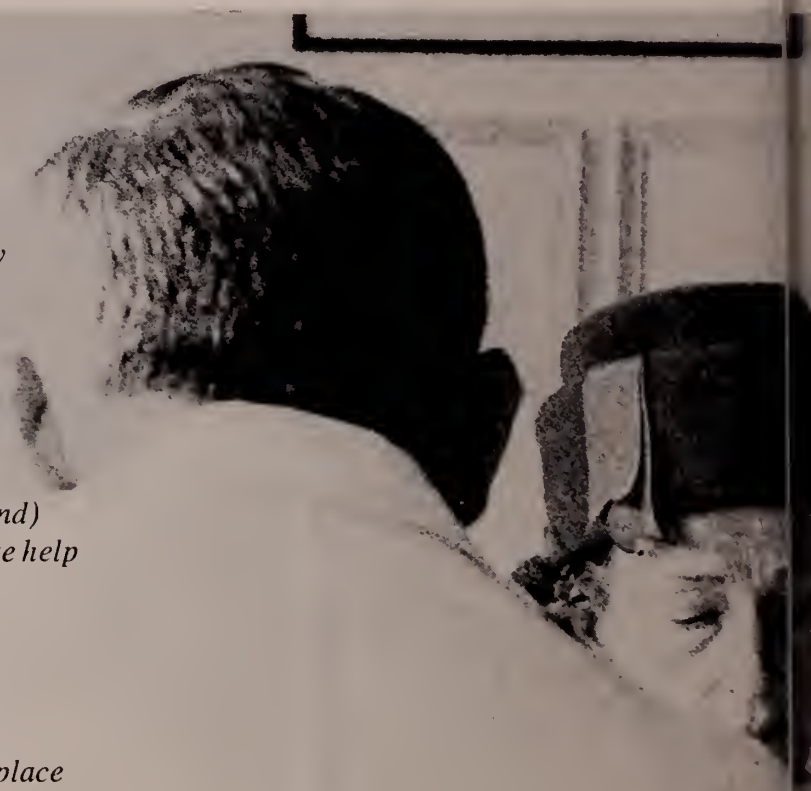
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The Mediatric Age:
There is a growing senescent body of people who –either from lack of motivation, or as a result of surgery, trauma, or extended illness–are on their way to malignant inactivity...



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Unfortunately, there is no cure. But there are, largely through your own interest and direction, ways to help them back to a more active and useful life. There are medicines, too, designed to help. One such has proved useful in clinical practice:



"A steroid-nutritional compound (Mediatric) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging . . . This therapy resulted in improvement of 75 per cent of the patients . . ."

McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

"Mediatric (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied . . . The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.

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Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
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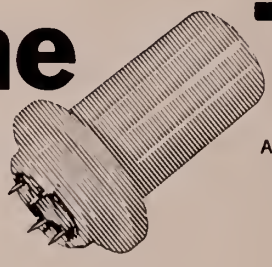
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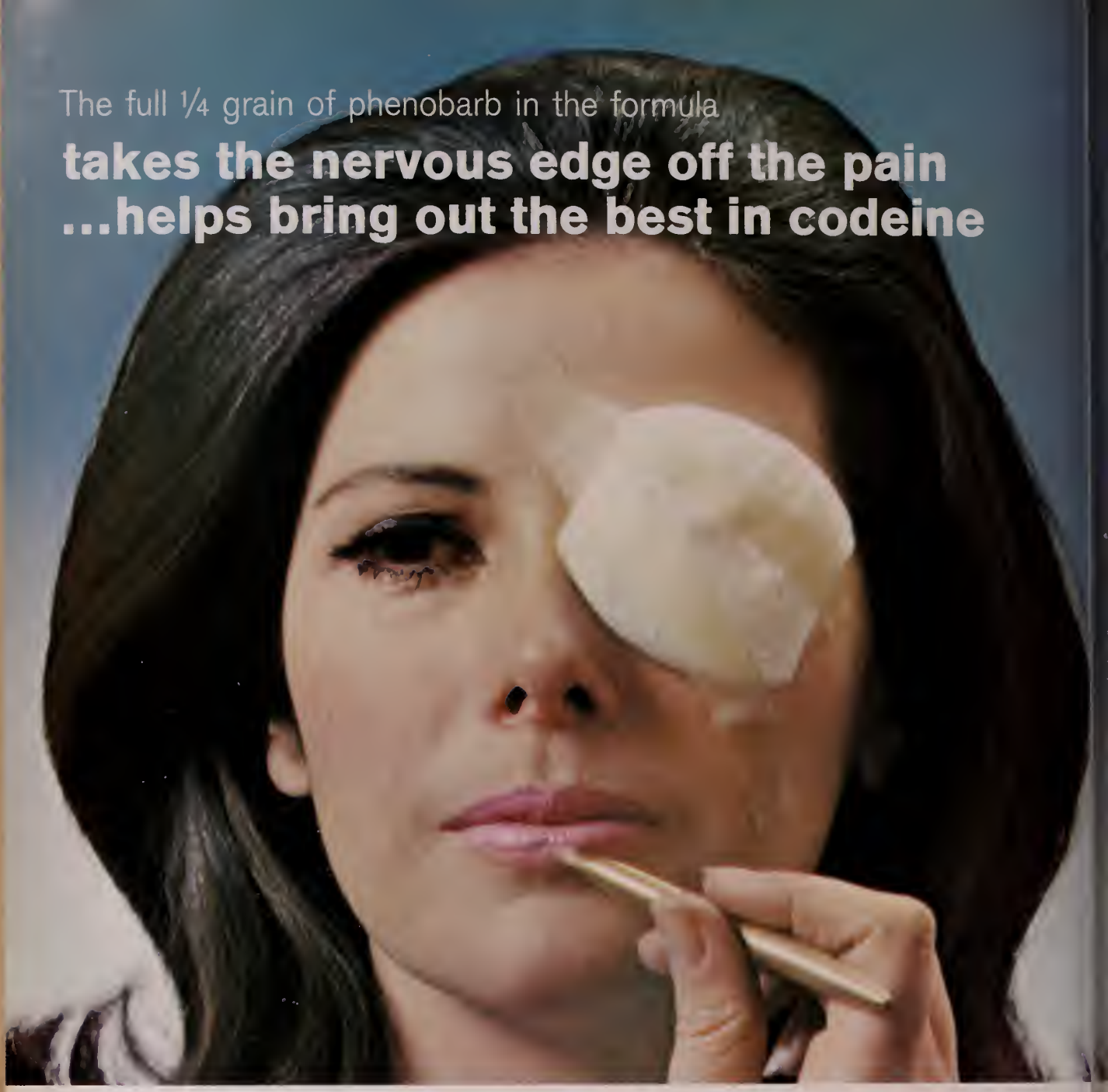
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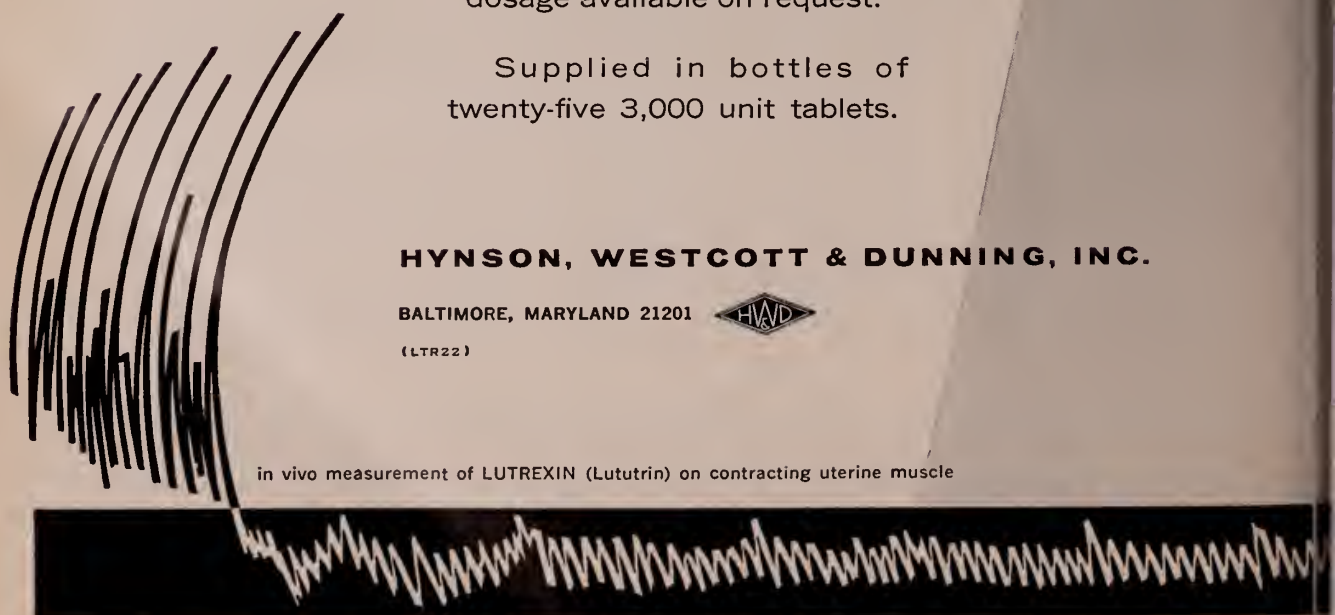
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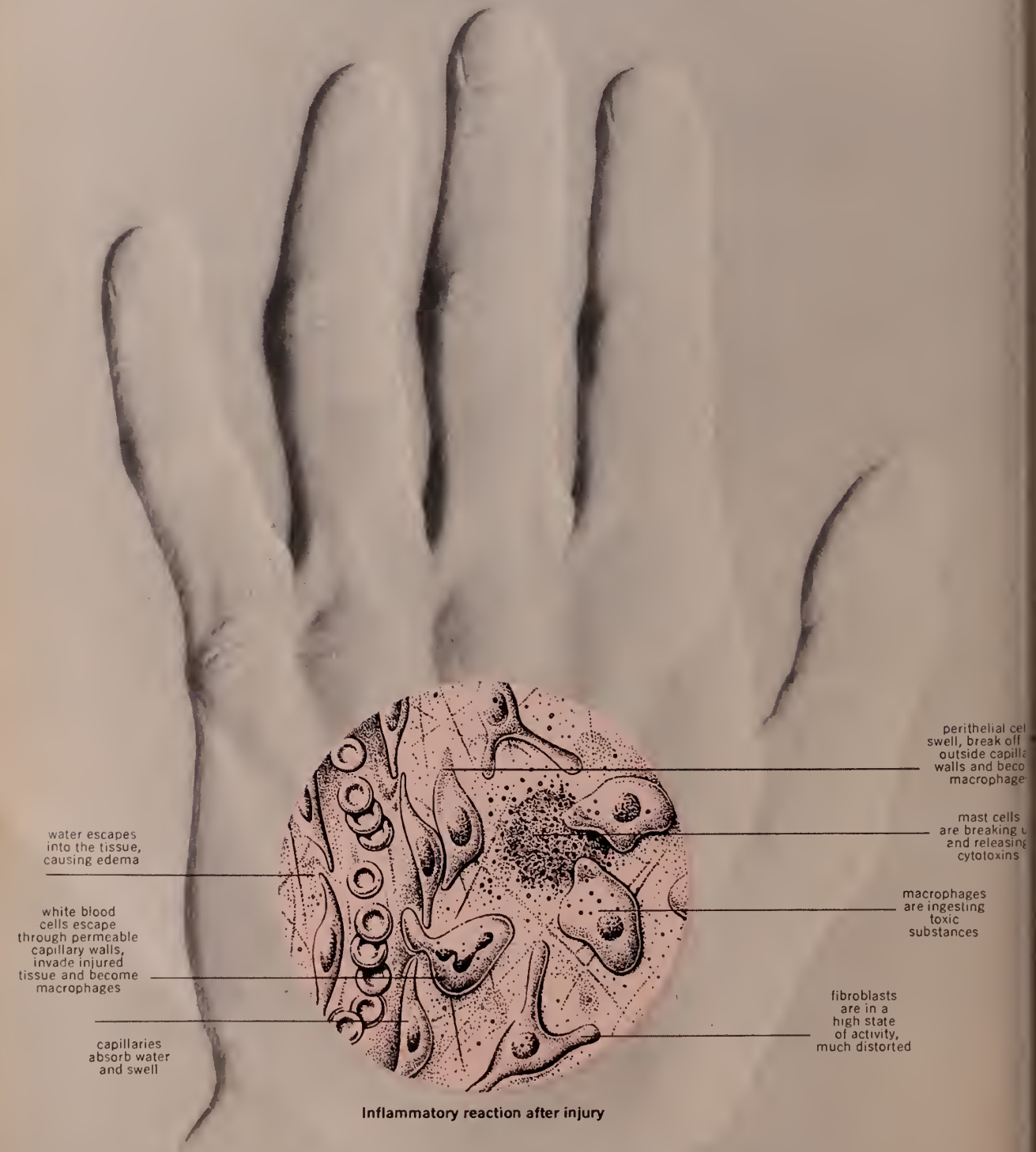
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References: 1. Kanee, B.: Canad Med Ass J 88:999 (May 18) 1963. 2. Scholtz, J. R.: Calf Med 95:224 (Oct.) 1961. 3. Jansen, G. T., Dillaha, C. J., and Honeycutt, W. M.: Arch Derm 92:283 (Sept.) 1965.

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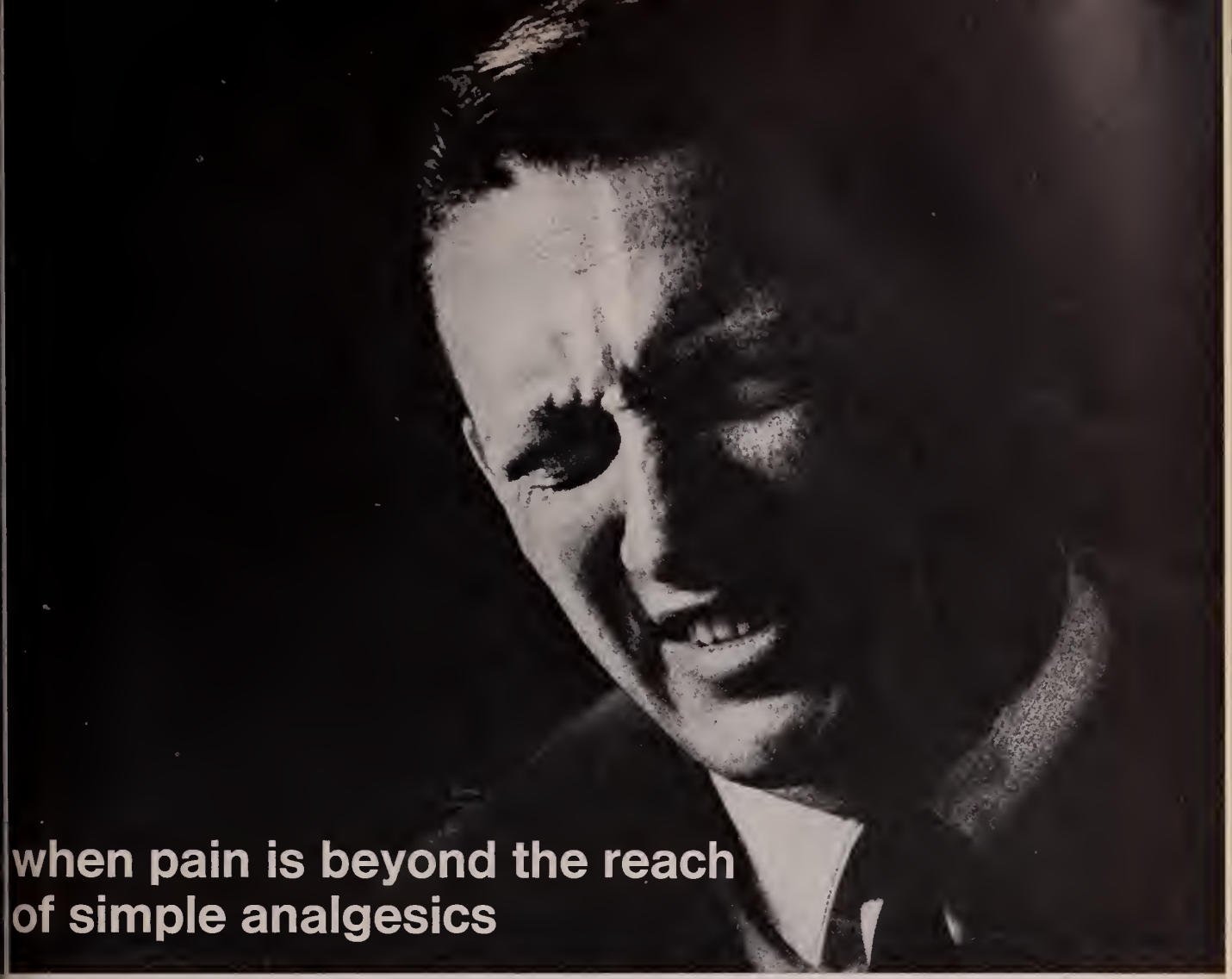
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this issue: emergency anesthesia and the common cold

When emergency anesthesia is complicated by the common cold

Barry Belonsky, M.D., F.A.C.A.
Staff Anesthesiologist, Hospital of The Albert Einstein College of Medicine, New York City



Medical facilities are often presented with unfamiliar patients who have unknown health histories. This is particularly true in emergency situations that arise due to accidents or acute illnesses. These cases may need prompt care requiring anesthesia, and if they involve colds, nasal allergies or other upper respiratory infections, can account for many complications which make up a major hazard during emergency anesthesia.

Administration of general anesthesia to a patient with a cold or upper respiratory infection is a hazardous undertaking. It should be avoided if at all possible. Indeed, the presence of U.R.I. is good reason for postponement of elective surgery.[1] In emergency surgery, regional or local block should be considered, but if general anesthesia is mandatory, it should be approached with utmost caution.

Since the attitude of "emergency surgery — hurry" has been replaced by "emergency surgery — watch out",[2] a knowledge of the complications is a great help in preventing them. Here is a brief outline of the problems involved and their treatment. Prevention of the complications is discussed later.

Complications during the induction of anesthesia

Most of the complications are a direct result of secretions and some a result of accompanying secondary infection. For example, *airway obstruction* due to excessive secretions occurs very commonly and is the direct effect of the cold. Respiratory exchange may be obstructed at any time during anesthesia because of excessive secretions, but is most likely to occur during induction. Suction apparatus must be available to overcome this.[3]

Excess secretions which stimulate and irritate the epiglottis and vocal chords can cause *laryngeal stridor and obstruction*. This can lead to complete laryngeal closure with resultant anoxia and death.

Bronchospasm and laryngospasm can result from secretions penetrating the bronchi and bronchioles. In laryngospasm, there are both inspiratory and expiratory stridor and difficulty in inflating the chest; in bronchospasm there is an expiratory wheeze, but not as much difficulty in inflation, although some resistance may be felt. Stridor is due to partial or complete closure of the vocal cords in spasm and the "crowing" sound is almost pathognomonic.

Secretions obstruct the nasal airways. This produces *difficulty in ventilation* through the mouth until the patient is deep enough to place an oral airway. An intravenous agent can be given to facilitate the induction of anesthesia.

Difficulties can arise if intubation is performed to ventilate the patient. For example, teeth can be broken by too vigorous attempts at intubation, or the intubation itself may be technically difficult due to secretions obstructing the view of the glottis. The postoperative sequelae of intubation ranges from mild laryngitis to pneumonia with atelectasis, and are seen far more commonly in patients suffering from colds than in normal patients.



Successive stages of laryngospasm which produce the characteristic stridor or "crowing" sound.



Progression of bronchioles into bronchospasm.

Complications during the maintenance of anesthesia *Bronchospasm* can occur in an unintubated patient due to secretions entering the bronchial tree from above, and acting as an irritant to the bronchi and bronchioles. Secretions accumulate quickly and the patient has to be suctioned continually. The whole cycle of coughing, bucking, laryngospasm and bronchospasm may ensue. The difficult decision here is whether it is better to suction the patient continually or to use an endotracheal tube which protects the cords and bronchi but introduces the risk of attendant complications.

Postoperative complications Postoperatively, complications can be more serious than even the intraanesthesia complications, and occur much more frequently in a patient who has been intubated.[4]

Sore throat and pharyngitis can result both from the preoperative upper respiratory infection and from the drying of the mucous membranes which occurs during anesthesia.

Tracheitis and bronchitis often result from secretions trickling down the tracheobronchial tree.

Laryngitis is frequently seen in patients with upper respiratory infections who have been intubated. There is a significant increase in the incidence of laryngitis compared to that in patients without upper respiratory infections.

Subglottic edema is a condition which occurs mainly in children who have been intubated. This pathology results from an exudate developing in the areolar tissue just below the cords. Because of the small size of the child's trachea, even a 1 mm increase in size of the mucous membrane can severely impair the air passage. Children exhibit this by severe expiratory stridor and may even become cyanotic. This may so severely embarrass the child's breathing that it must be treated vigorously. Most authorities agree on the treatment[5,6,7,8] consisting of a high oxygen concentration in the inspired air (60%), plus high humidity (close to 100%). Adequate parenteral fluid intake and slight cooling of the body temperature (by a cooled oxygen tent) also help in mild cases. In severe cases, there may be hypoxia which increases the restlessness and the oxygen demand rises. Sedation is often necessary, although concomitant depression of the respiratory center is undesirable. An antihistaminic accomplishes this purpose well, and adds sedation. Since there is always a possibility that an allergic response plays a role in edema, some relief of the respiratory distress may occur. Steroids should be used to control inflammatory and allergic phenomena and swelling. If all this fails, and the patient is still restless and hypoxic, a tracheostomy should be performed immediately.

(concluded on following page)



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Cross section of trachea showing subglottic edema and lumen reduction due to mucous membrane congestion.

Pneumonia may also follow anesthesia administered to a patient with a cold. This can be caused by accumulated secretions becoming secondarily infected and causing consolidation of the lung. *Atelectasis* of the lung can result if one of the bronchioles becomes plugged by secretions, preventing aeration of the distal part of that lung. This is seen more frequently following upper respiratory infection because dry anesthetic gases aggravate the infection, causing secretions to change from watery to thick and viscid, and consequently difficult to suction.

Prevention of complications

The first rule to prevent complications, of course, is to use a regional or local anesthesia whenever possible. But when emergency surgery is a must, in spite of the presence of a cold, allergy, or upper respiratory infection, here are some ways to prevent complications.

Give nose drops preoperatively. This can help shrink the congested nasal mucous membranes and reduce secretions for better air passage. (Results of this method are sometimes unsatisfactory because of the short duration of effect or rebound congestion.) For longer effect, oral antihistamines with nasal decongestants are often given to provide and maintain a drying effect on secretions.

To clear the tracheobronchial tree, instruct the patient to cough preoperatively. Cold steam or water nebulizers effectively humidify the nasal, pharyngeal and bronchial passages and often make the patient more comfortable. Tenacious secretions become more watery under humidification, clear more thoroughly preoperatively and are more easily suctioned from the airway during anesthesia.

Give intravenous fluids to those patients who appear dehydrated due to a cold. In a well hydrated patient the respiratory tract secretions are less viscid and more watery. This is particularly true in asthmatics.

Summary:

Administration of emergency anesthesia to a patient with a cold or upper respiratory infection can lead to a chain of events that may result in increased postoperative morbidity and even death. This is because of the excess secretions formed in these conditions. Preoperative measures to prevent or reduce these secretions should be undertaken and will result in smoother and safer anesthesia.

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MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9,10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

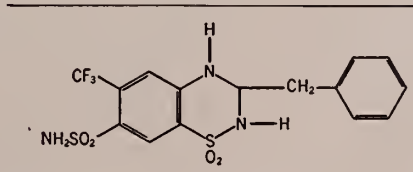
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: **1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.



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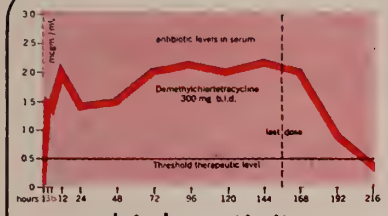


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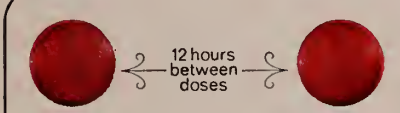
Contraindication—History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort.

Precautions and Side Effects—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

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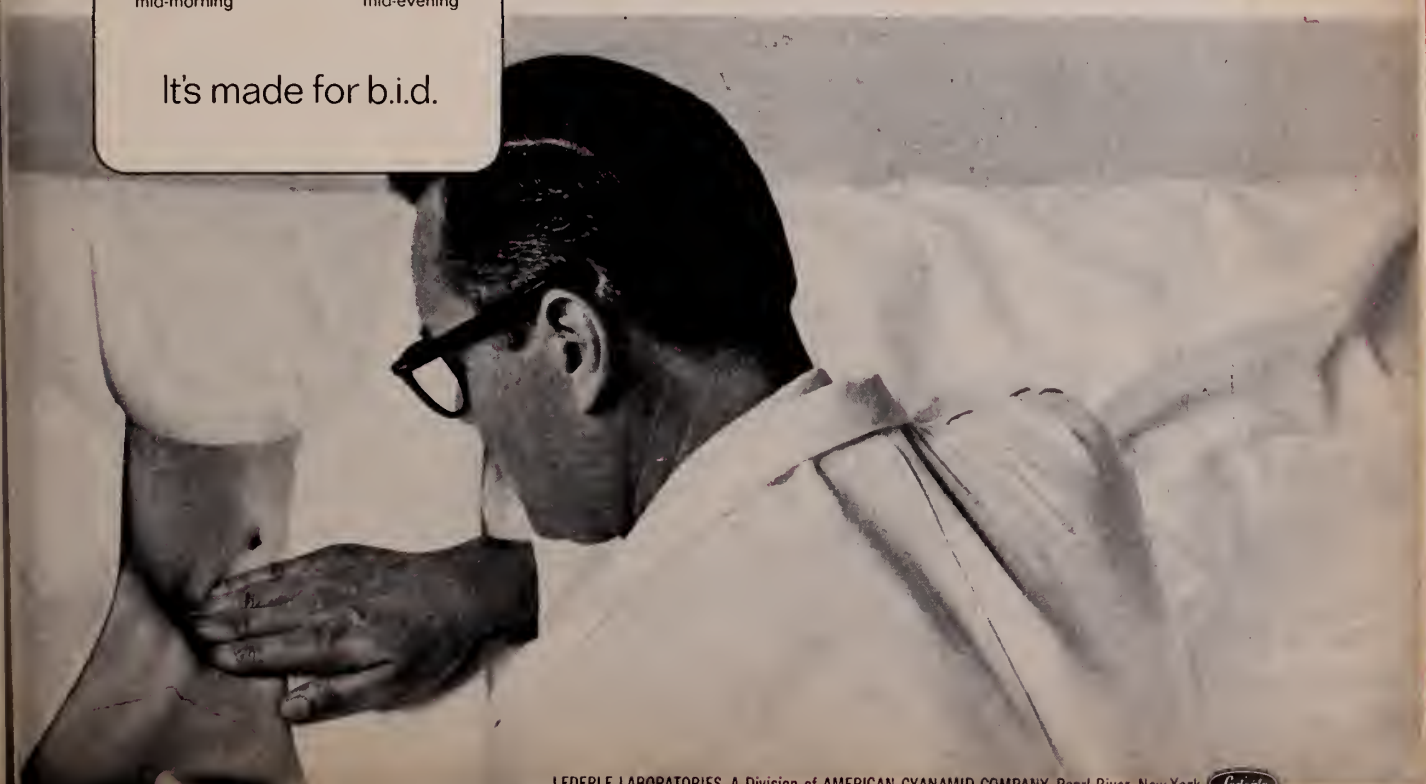
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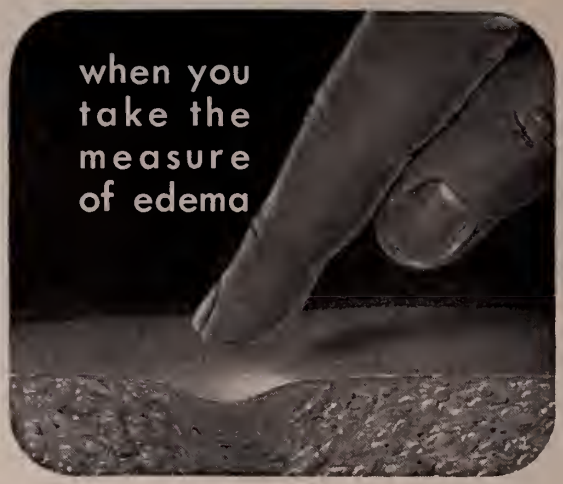
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WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

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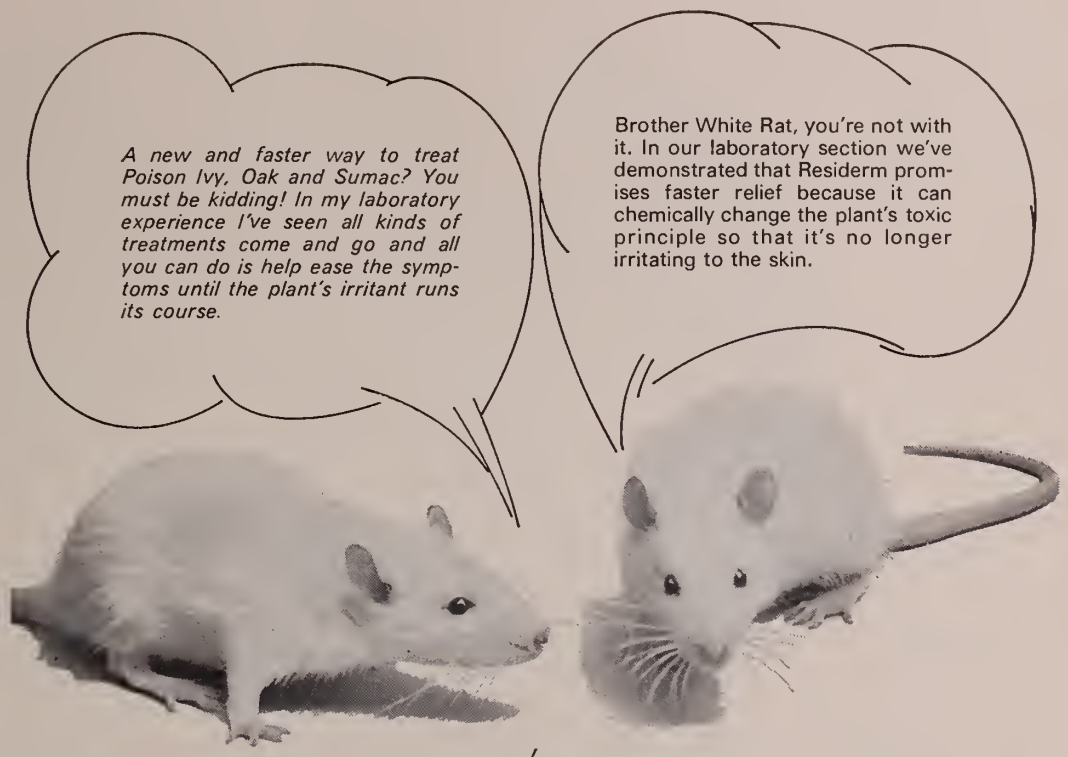
Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic tetor, tremor, confusion and drowsiness are signs of impending pre-coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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CONTENTS • Pages 449 to 494

EDITORIALS

Financial Barriers To Medical Study 449
William L. Vroom: 1866-1966 449
Another Plague Passes 450
It's Not The Cost Per Pill That Counts 451

ORIGINAL ARTICLES

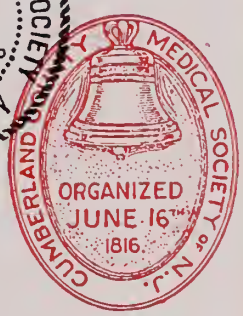
Obturator Hernia
William A. Dwyer, Jr., M.D., Paterson 451
Preliminary Clinical Evaluation Of An Appetite Suppressant
Harold S. Feldman, M.D., Ph.D., Livingston 454
Use Of A Diuretic In Breast Engorgement
Donald R Reisfield, M.D. and Frank L. Paret, M.D., New Brunswick 458
Aorta Catheterization For Thoracic Aortography
Victor D'Ambrosio, M.D., Murray Hill 462
Percutaneous Renal Biopsy
Edwin Kellerman, M D. and Milton Ackerman, M.D., Atlantic City 465
Detection of Latent Diabetes
William F. Haynes Jr., M.D., Princeton 469
Rehabilitation Of The Disabled Worker
Jarvis Smith, M.D., Trenton 473
Blood Pressure: A Problem In Hydraulic Engineering
Arthur R. Harmon, Port Republic 477

STATE ACTIVITIES

Committee and Council Chairmen 461
Bicentennial Souvenirs 472
Special Committees and Liaison Representatives 484
OBITUARIES 488
ANNOUNCEMENTS 490
BOOK REVIEWS 491
RESPIRATORY DISEASES ABSTRACTS 493

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In its bicentennial year, the official seal of The Medical Society of New Jersey shares prominence with the official seals of those component societies celebrating their sesquicentennial anniversaries. According to the proceedings of the New Jersey Historical Society ("An Outline of the History of the Medical Society of New Jersey to 1900"), the first county medical societies organized in 1816 were: Somerset, May 21; Essex, June 4; Cumberland, June 6; Middlesex and Morris, June 11; and Monmouth, July 24.

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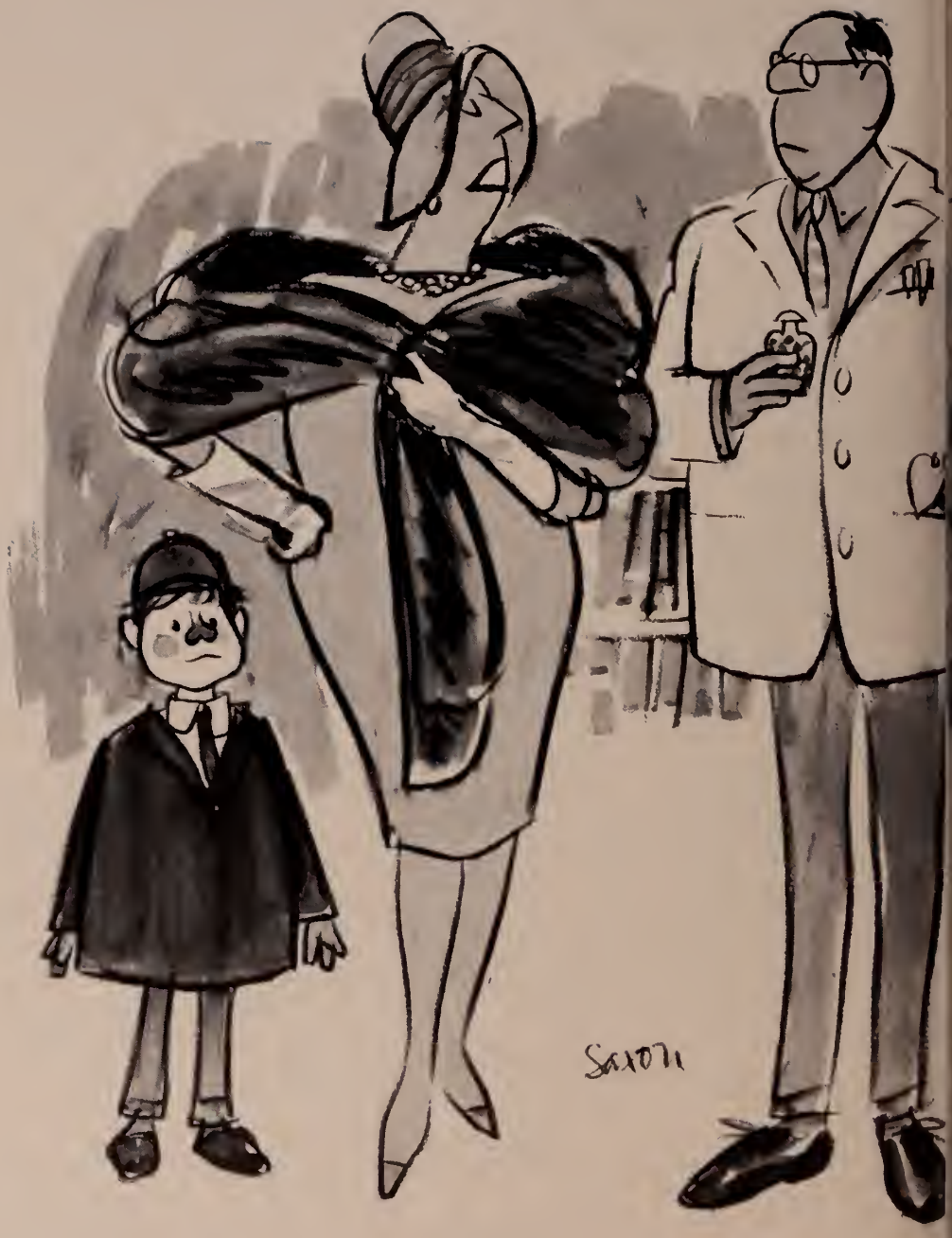
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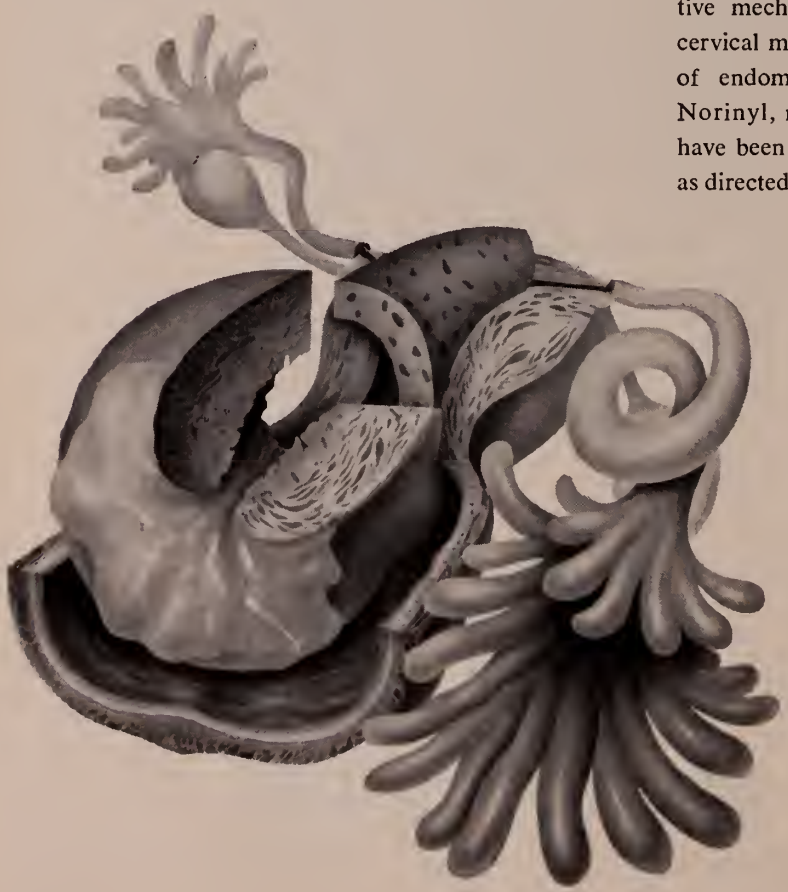
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Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.

Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

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References: **1.** Council on Drugs. JAMA 187:664 (Feb. 29) 1964. **2.** Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. **3.** Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. **4.** Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. **5.** Hammond, D. O.: Ibid. **6.** Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. **7.** Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. **8.** Kempers, R. D.: GP 29:88 (Jan.) 1964. **9.** Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. **10.** Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. **11.** Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. **12.** Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. **13.** The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. **14.** Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. **15.** Merritt, R. I.: Appl Ther 6:427 (May) 1964. **16.** Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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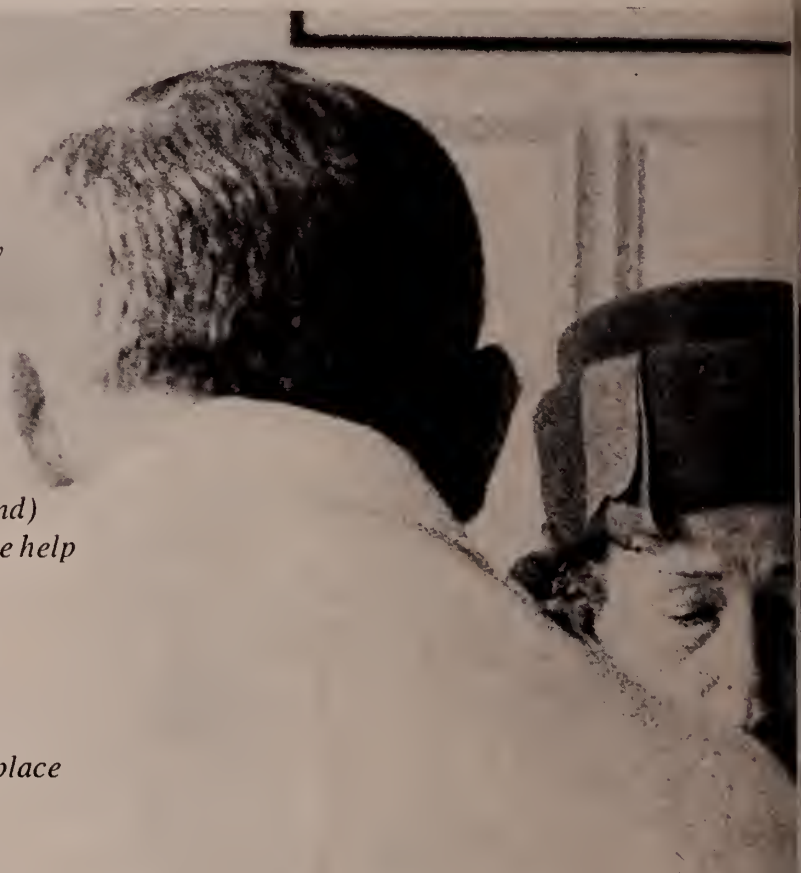
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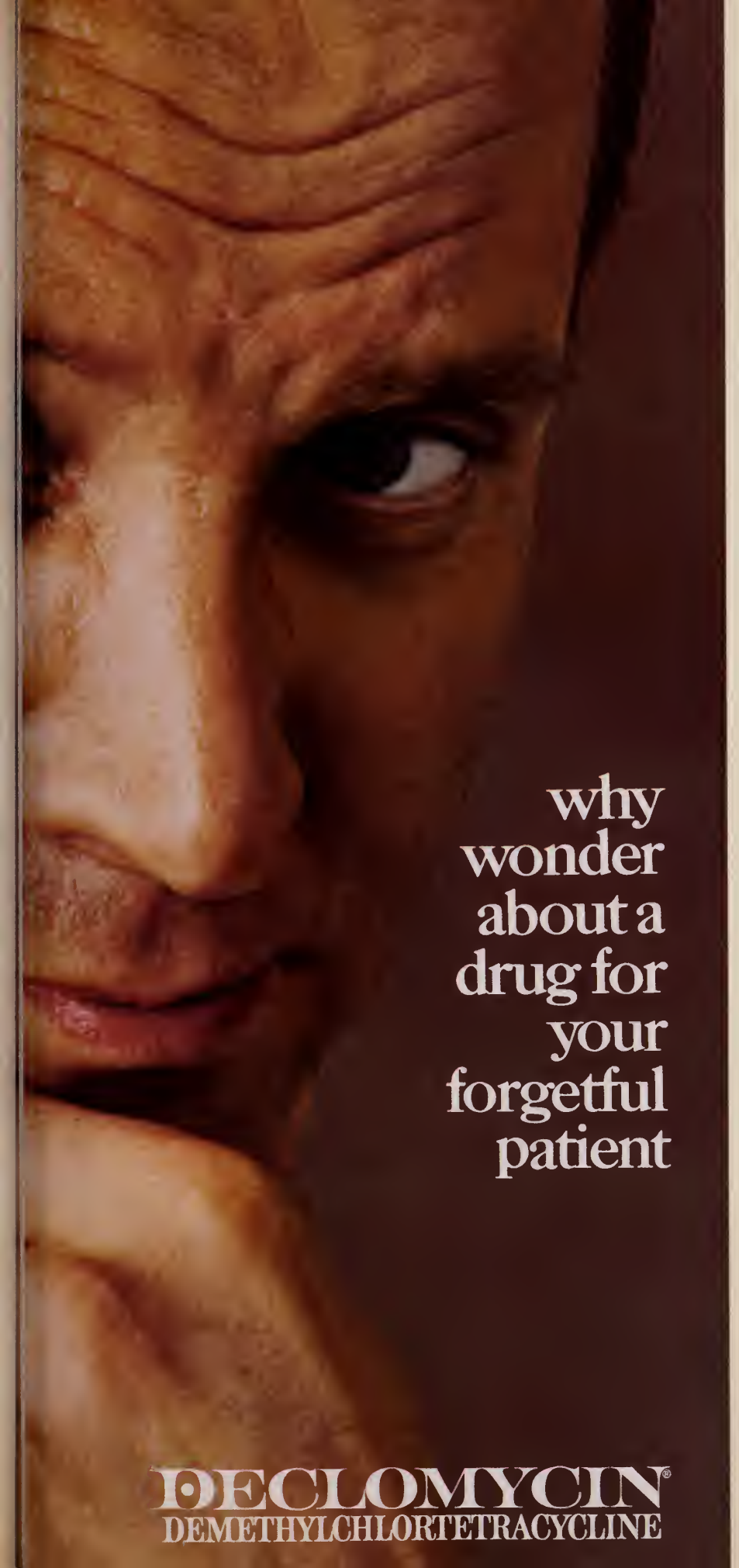
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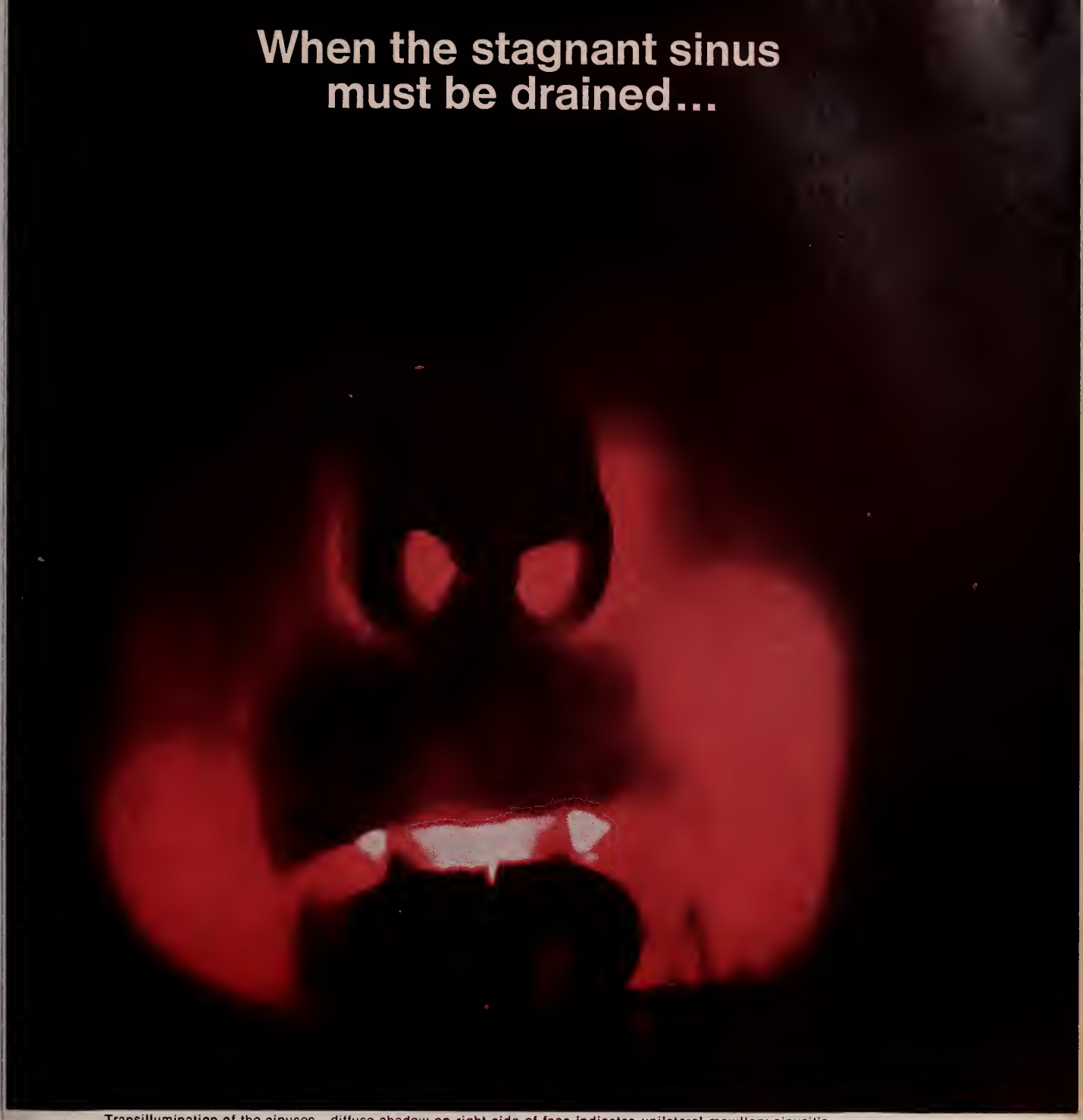
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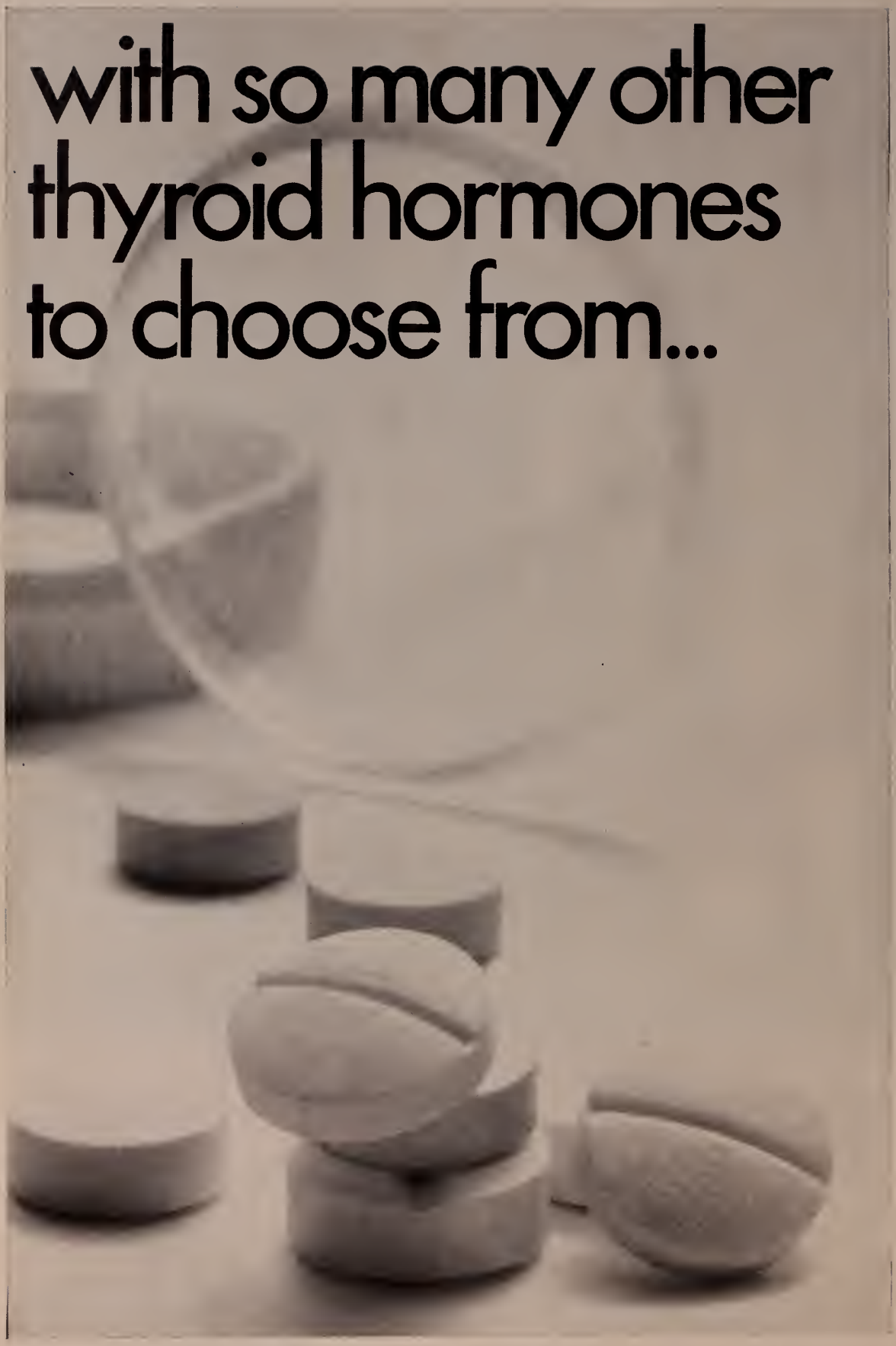
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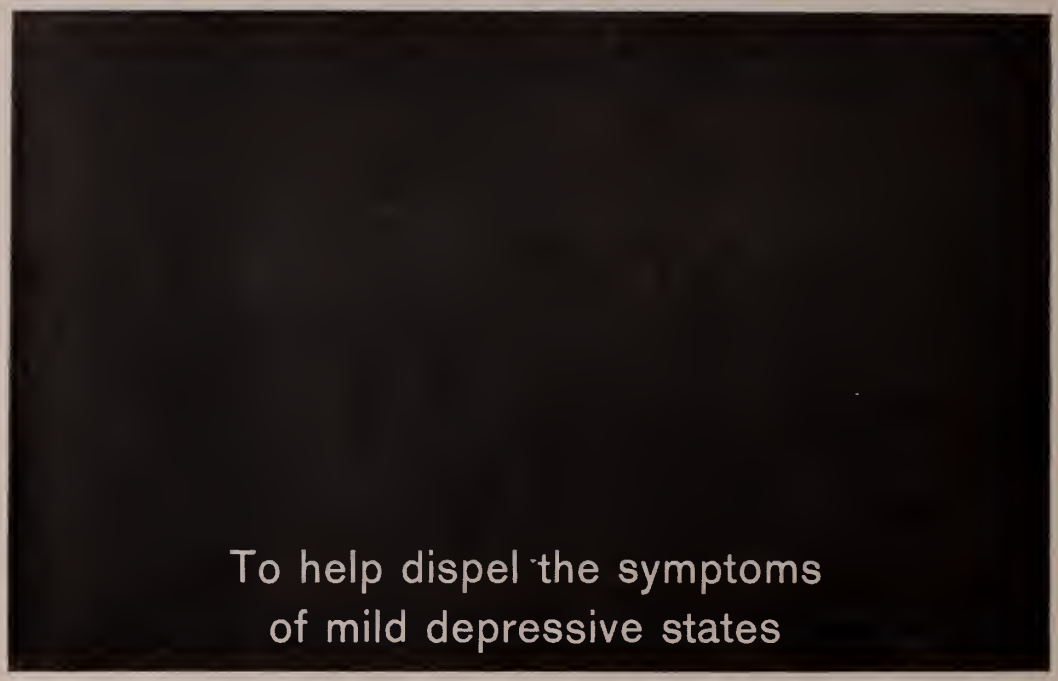
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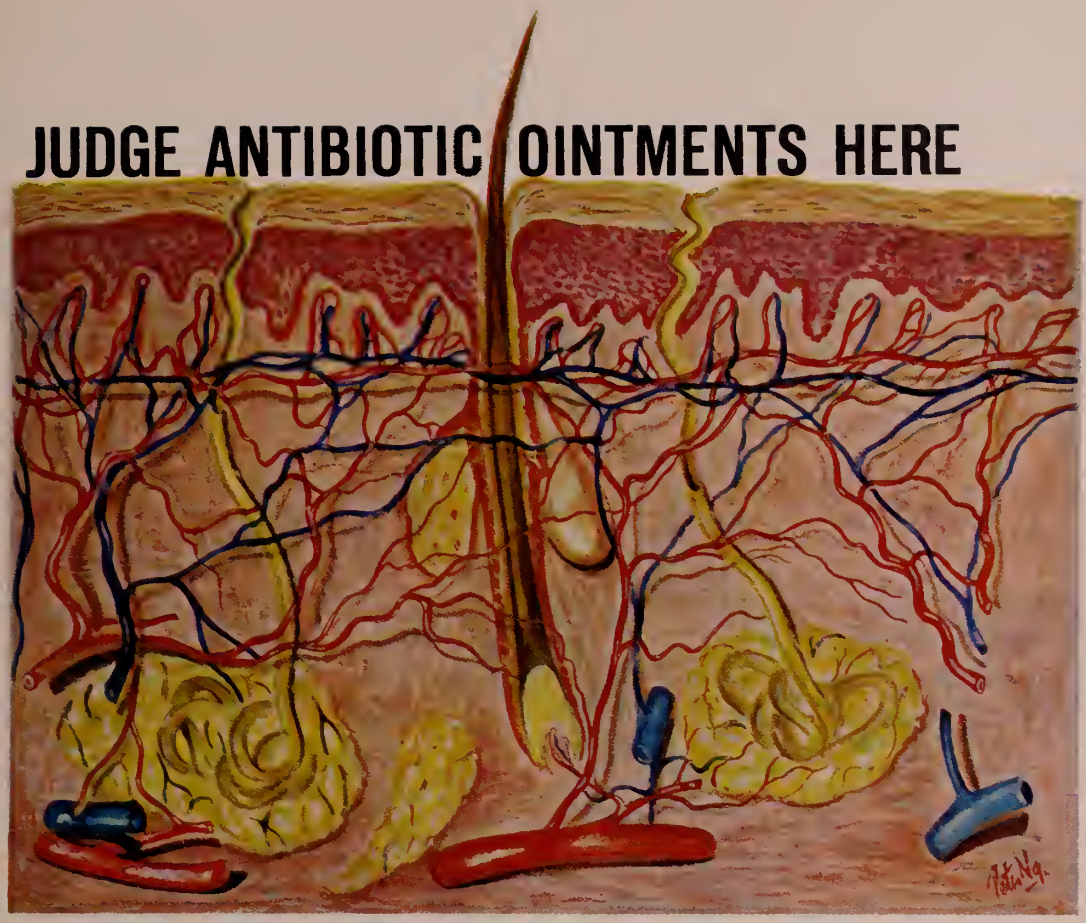
Formulas: Each 'Dexamyl' Spansule® capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*.

Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Do not use in patients taking MAO inhibitors. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester. *Side effects:* Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

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Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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a new formulation that relieves pain in tension headache and neuralgia

Dialog is a combination of 15 mg allobarbital and 300 mg acetaminophen. Allobarbital, a proven barbiturate, provides desirable sedation in patients experiencing pain and discomfort. Acetaminophen is a nonsalicylate analgesic-antipyretic, well tolerated and useful in a wide range of mildly painful and febrile conditions.

Dialog is well tolerated, even by those sensitive to aspirin. It is nonirritating to the gastrointestinal tract and, in recommended dosage, has no adverse effects on the kidneys.

- Raises the pain threshold
- Suppresses the pain-producing mechanism
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2/3449 MK-3

for tension headach

Dialog™
(allobarbital and acetaminophen CIBA)

Indications: For relief of pain and discomfort of simple headache; neuralgia, myalgia, and musculoskeletal pain; dysmenorrhea; bursitis; sinusitis; fibrositis. Also indicated to reduce fever and to relieve discomfort due to respiratory infections, influenza, and other febrile conditions.

Contraindication: Not recommended during pregnancy.

Caution: May be habit-forming. Do not use in patients sensitive to barbiturates or in those with moderate to severe hepatic disease.

Side Effects: Nausea, transitory dizziness, rash. Overdosage of allobarbital produces symptoms typical of acute barbiturate excess.

Dosage: *Adults:* 1 or 2 tablets every 4 hours. Not to exceed 8 tablets in 24 hours. *Children 6 to 12:* ½ to 1 tablet every 4 hours. Not to exceed 4 tablets in 24 hours.

Supplied: *Tablets* (white, scored), each containing 15 mg allobarbital and 300 mg acetaminophen; units of 3 bottles of 30.

For your convenience—prescription-size bottle of 30.

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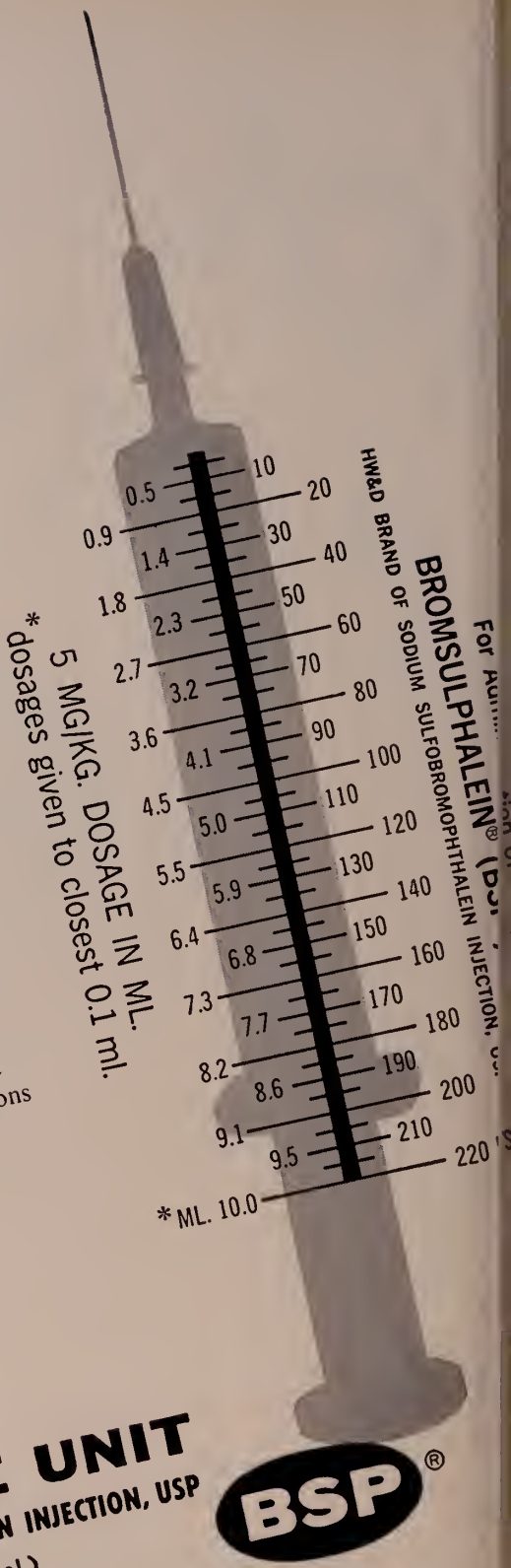
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(BSPO2)



Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

A balanced formulation

Providing single-dose therapy for the prevention of lactation and breast engorgement, Deladumone OB is a potent androgen-estrogen combination with a prolonged action. The optimal balance of androgenic and estrogenic hormones achieved in this preparation minimizes the disadvantages inherent in single hormone therapy, such as rebound breast engorgement. Involution of the uterus and resumption of menstrual cycles are not affected.

As reported in a recent published study (Roser, D. M.: Obstet. & Gynec. *27*:73, 1966), Deladumone OB provided good suppression of breast engorgement in 95.3% and suppression of lactation in 81.1% of 86 obstetrical patients. These results are in general agreement with those of many earlier investigations; in several studies this injectable androgen-estrogen combination proved to be superior to oral medication.

Dosage:

As a single injection of 2 cc. before the onset of the second stage of labor.

Contraindications:

Established or suspected mammary cancer or genital malignancy.

Precautions and Side Effects:

Certain patients may be unusually responsive to either estrogenic or androgenic therapy. In such individuals virilization, uterine bleeding or mastodynia may occur.

Supply:

Deladumone OB, providing 180 mg. testosterone enanthate and 8 mg. estradiol valerate per cc., is available in 2 cc. Unimatic® disposable syringes and in 2 cc. vials. Both preparations are dissolved in sesame oil, with 2% benzyl alcohol as a preservative. *Before use, consult product literature for full prescribing information.*

Deladumone® OB

Squibb Testosterone Enanthate (180 mg./cc.) and Estradiol Valerate (8 mg./cc.)

Single-dose injection for lactation inhibition

SQUIBB *'The Priceless Ingredient' of every product is the honor and integrity of its maker.*



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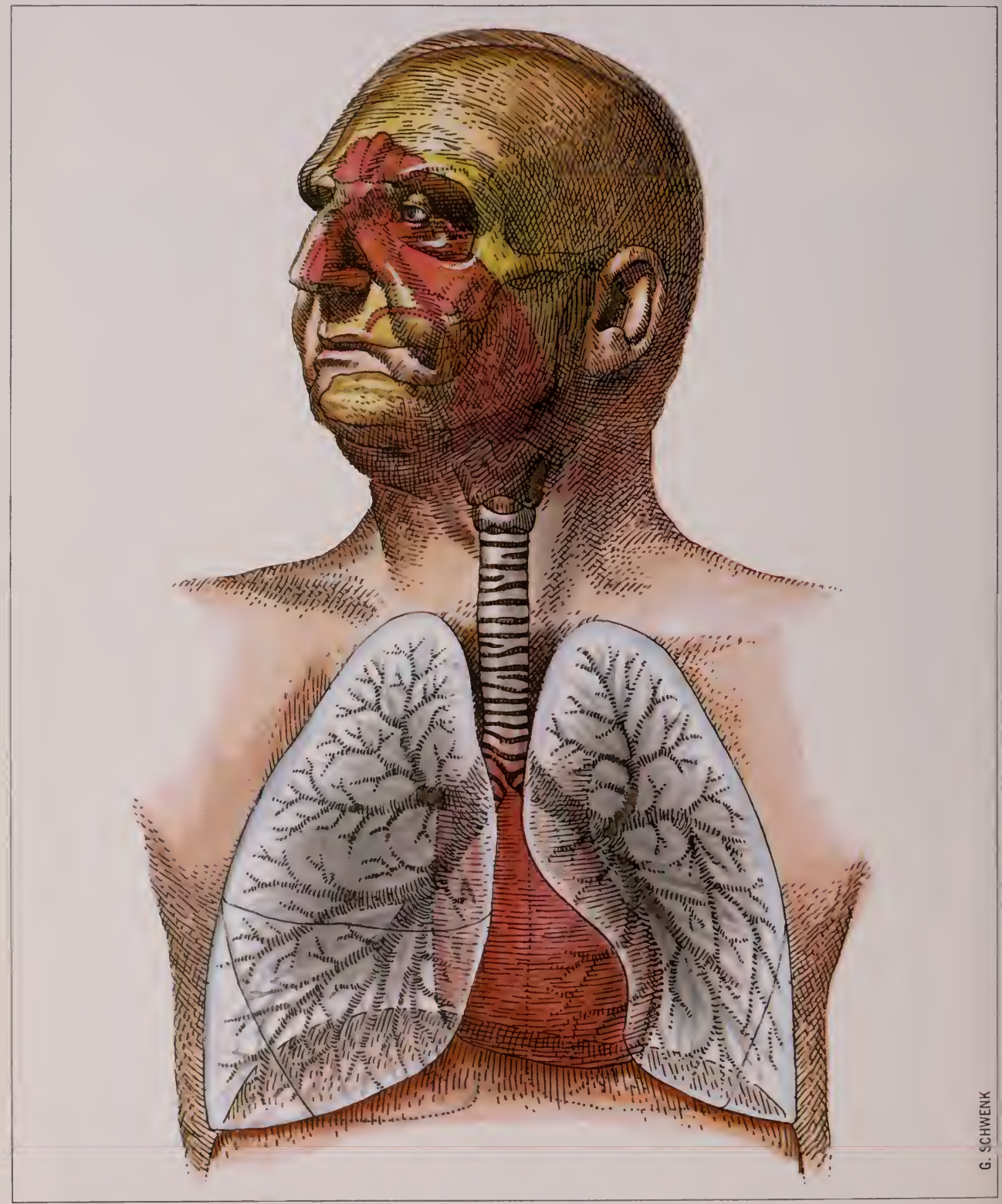
A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Pogge, M.D., Director of Medicine.



this issue: the common cold and the aging patient

the common cold and the aging patient

Louis J. Vorhaus, II, M.D., F.A.C.P.



Effects of aging on the anatomic and physiologic aspects of the respiratory apparatus.

The chest becomes more fixed, less mobile and less elastic as the bronchial walls and thoracic ligaments lose elasticity. The diaphragm and intercostal muscles atrophy and weaken. The lungs become smaller, flabbier and weigh less, decreasing vital and total lung capacity, increasing residual volume and the alveolar dead space.

Sir William Osler described pneumonia as the welcome friend of the aged patient, because the patient with pneumonia usually died quietly. But today, the well-informed physician is an even better friend of the aging patient, since it is better to live than to die, no matter how quietly.

One of the first avenues of approach in the control of the hazards of respiratory disease in the aging patient is prompt and proper attention to the common cold or upper respiratory infection. The common cold may be the first step in the relatively short path to lower respiratory infection, broncho-pneumonia and death. This train of events occurs frequently among older persons. Indeed, pneumonia is one of the most common causes of their admission to hospitals and ranks high on the list of geriatric killers. Colds are more debilitating in elderly people and the aged are more likely candidates for secondary infections such as sinusitis and bronchitis. These infections, in turn, are more prone to lead to broncho-pneumonia, because of lowered resistance and anatomic and physiologic changes in the lungs of the elderly.

What is different about the respiratory tree of an aged person and that of an otherwise healthy younger adult? Aging certainly takes its toll on all parts of the body, affecting both anatomic and physiologic aspects of the respiratory apparatus. These changes are in part due to the wear and tear that occurs over the years; the repeated bouts of respiratory infection, long exposure to atmospheric pollutants, to occupational inhalants, smoking, malnutrition, obesity, inactivity and the development of other diseases which may affect the lungs.

With the passage of years, the lungs change. They become scarred and emphysematous and lose their compliance. The whole chest becomes more fixed, less mobile and less elastic.

The anatomic changes that occur in aging render the lungs less efficient. Tests of pulmonary function in senescence show a deterioration characterized by a decrease in vital capacity and total lung capacity, an increase in residual volume and alveolar dead space. Maximum breathing capacity is reduced and uniformity of ventilation deteriorates. These problems are often aggravated by the obstructed breathing, fever and secondary infection associated with the common cold, placing an additional stress on the entire cardiopulmonary reserve.

In addition, the efficiency of a cough is below par in older persons even though they are in good health. This is partly due to the decreased respiratory excursions and distensibility of the chest wall, and partly from loss of elasticity of bronchial walls which tend to make them collapse in a cough.

The elderly patient's resistance to infection is often reduced. Nutritional deficiencies are more common in aged people. There is some evidence to indicate that their capacity to respond to stress is less efficient. Finally, there is often relatively meager symptomatic response to acute disease. The absence of obvious or dramatic clinical signs and symptoms of severe illness is particularly dangerous because, coming as it

(concluded on following page)

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Triaminic® **timed-release tablets**

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Each timed-release tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
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Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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does in a person whose defenses are weakened both locally and systemically, pulmonary disease may progress rapidly to irreversible stages before medical attention is sought. Respiratory infection is especially hazardous because the aged patient responds badly to hypoxia. Not only is his response to oxygen lack impaired, but the work of breathing, due to decreased compliance of the lung and increased stiffness of the thorax, is markedly augmented.
Many patients late in life are in a precarious and delicate cardiopulmonary balance which is easily decompensated from relatively minor insults such as colds and upper respiratory infections.

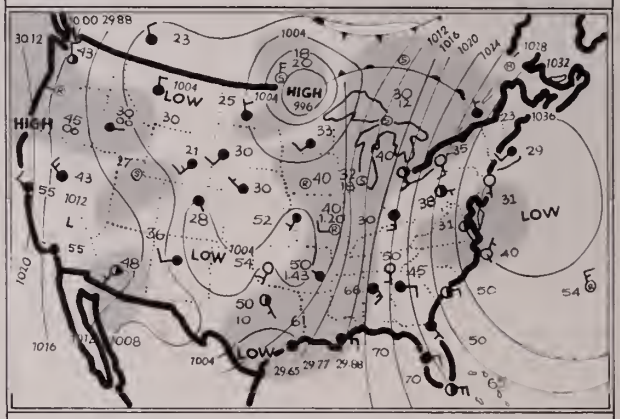
For all of these reasons, geriatricians long have stressed the importance of preventing respiratory insults. Today we have better ways of treating respiratory infection, improved techniques for clearing the lungs and bronchial tubes of secretions and better understanding of ways of improving ventilation. We possess a broader spectrum of antimicrobial agents including newer ones to deal with previously resistant organisms. Even so, the death rate from pneumonia is high in older people, and it is preferable to avoid the disease than to treat it. To do so, attention must be paid to the general maintenance of good health and all that implies, as well as to the prevention, elimination and treatment of associated conditions that predispose to or cause pneumonia such as chronic upper or lower respiratory infection, respiratory allergy, chronic sinusitis and exposure to inspired irritants.

Colds and other minor respiratory infections, which favor the development of broncho-pneumonia, should be treated vigorously and promptly, particularly those patients whose aging process has been accompanied by the development of chronic pulmonary disease. Upper respiratory passages should be cleared with decongestants. Sinuses should be drained adequately. And, when indicated, appropriate antimicrobial therapy should be instituted before serious infection of the lower respiratory tree supervenes.

In decades past it was understandable that physicians welcomed pneumonia for the aged patients because it offered them a quiet and peaceful demise. Today we recognize that in many cases, peaceful as it may have been, such deaths were often avoidable. With the current knowledge and understanding of the problems that respiratory infections impose on aging people, vigilant medical attention can often restore them to a vigorous, rewarding and productive life so that the many opportunities that exist today for people to enjoy their golden years are realized and not stolen by untimely death.

References 1. Steiglitz, Edward J., Geriatric Medicine, Medical Care of Later Maturity, 3rd edition, J. B. Lippincott Co., Philadelphia, 1954. 2. Norman, J. R., Schweppe, I. H., Salazar, E. and Knowles, J. H., Lung Volumes and Aging, Journal of the American Geriatrics Society, 12, pp. 38-47, January 1964. 3. Penman, Robert W. B., Hypoxia and Respiratory Failure, Geriatrics, 18, 807-814, November 1963. 4. Middleton, William S., Some Medical Dissections on Aging, Geriatrics, 18, 168-73, March 1963. 5. Cole, M. B. and Roberts, F. E., Clinico-Pathologic Study of Emphysema, Journal American Geriatrics Society, 12: 415-419, May 1964. 6. Horton, Glenn, Testing of Pulmonary Function, Geriatrics, 17:73-81, February 1962. 7. Banyai, Andrew L., Cough and its Management in Elderly Patients, Geriatrics, 14:621-630, October 1959. 8. Howell, T. H. and Piggot, A. P., Morbid Anatomy of Old Age, Geriatrics, 8:267-72, March 1953.

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Tussagesic® provides up to 24-hour coverage of the tough cold with a single timed-release tablet dosed morning, midafternoon and at bedtime. Coughs are broken up, runny and stuffed noses are cleared and pain is relieved.

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Dextromethorphan hydrobromide	30 mg.
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Acetaminophen	325 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: Patient should not drive a car or operate dangerous machinery if drowsiness occurs. Except under professional care, do not give to patients under 12 yrs. or those who have persistent cough, high fever, heart or thyroid disease, hypertension or diabetes or use for more than 10 days.

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when congestion is complicated by sulfa-susceptible bacterial invaders in the upper respiratory tract...



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Each tablet contains: Triaminic® 25 mg. (phenylpropanolamine hydrochloride 12.5 mg., pheniramine maleate 6.25 mg., pyrilamine maleate 6.25 mg.); Trisulfapyrimidines, U.S.P. 0.5 Gm. (sulfadiazine 0.167 Gm., sulfamerazine 0.167 Gm., sulfamethazine 0.167 Gm.)

PHARMACOLOGY: Triaminic decongests and promotes drainage of nasal and paranasal passages, and prevents any further histamine-induced damage; the triple sulfonamides inhibit susceptible bacterial invaders. INDICATIONS: For congestion and infection of the upper respiratory tract caused by sulfa-susceptible organisms. DOSAGE: Adults: 2 to 4 tablets initially, followed by 2 tablets every 6 hours. Medication should be continued until patient has been afebrile for 3 days. ADVANTAGES: The advantages of Trisulfaminic in upper respiratory infections are: freedom from narcotics or alcohol; therapeutic reliability; safety; economy; ease of administration; freedom from potential sensitization to broad-spectrum antibiotics which may be reserved for lower respiratory or other infections caused by susceptible organisms. CONTRAINDICATIONS: Contraindicated in sulfonamide and antihistamine sensitivity, impaired renal function, pregnancy approaching term, and in premature infants and newborn infants during the first month of life. Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. WARNING: Use only after careful evaluation in patients with liver or renal damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions with administration of sulfonamides. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed periodically. Sulfonamide therapy may potentiate the hypoglycemic action of sulfonylureas. PRECAUTIONS: Use with caution in patients with histories of significant allergy or asthma. Assure an adequate fluid intake. Because the antihistamines may cause drowsiness of varying degree, warn patients about activities requiring alertness such as driving a car or operating dangerous machinery. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease and diabetes. ADVERSE REACTIONS: As in all sulfonamide therapy, the following reactions may occur: headache, nausea, vomiting, diarrhea, icterus, hepatitis, pancreatitis, urticaria, rash, fever, cyanosis, hematuria, crystalluria, proteinuria, blood dyscrasias, petechiae, purpura, neuropathy and injection of the conjunctiva and sclera. If one or more of these reactions occur, the drug should be discontinued. With antihistaminic therapy there have been reports of sedation varying from mild drowsiness to deep sleep, dizziness, lassitude, inability to concentrate, fatigue, incoordination, tinnitus, blurred vision, diplopia, euphoria, nervousness, insomnia, tremors, palpitation, hypotension, headache, chest tightness, urinary frequency, dysuria, tingling of the hands, dryness of the mouth, throat, and nose, gastrointestinal disturbances such as epigastric distress, anorexia, nausea, vomiting, constipation and diarrhea and very rarely, leukopenia and agranulocytosis. Adverse reactions reported with the use of sympathomimetic amines include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesicle sphincter spasm. PACKAGE INFORMATION: Trisulfaminic Tablets: Supplied in bottles of 100 tablets. CAUTION: Federal law prohibits dispensing without prescription.

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in any case,
usually gram-negative*

Therapy:

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(initial adult dose)

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

Winthrop

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a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

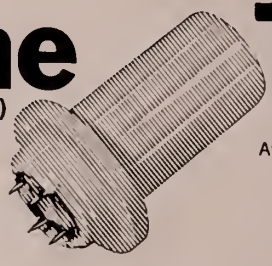
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In sinusitis, colds, or U.R.I., Dimetapp lets congested patients breathe easy again. Each Extentab brings welcome relief all day or all night, usually without drowsiness or overstimulation. Its key to success? The Dimetapp formula—Dimetane (brompheniramine maleate), a potent antihistamine reported in one study to have elicited side effects as few as the placebo,* teamed with decongestants phenylephrine and phenylpropanolamine—in a dependable 10- to 12-hour form.

*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

Contraindications: Patients hypersensitive to antihistamines. Not recommended for use during pregnancy.

Precautions: Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability, or excitement may be encountered.

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Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

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MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9, 10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

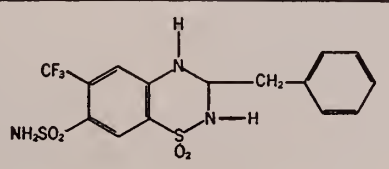
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c̄ K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

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Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

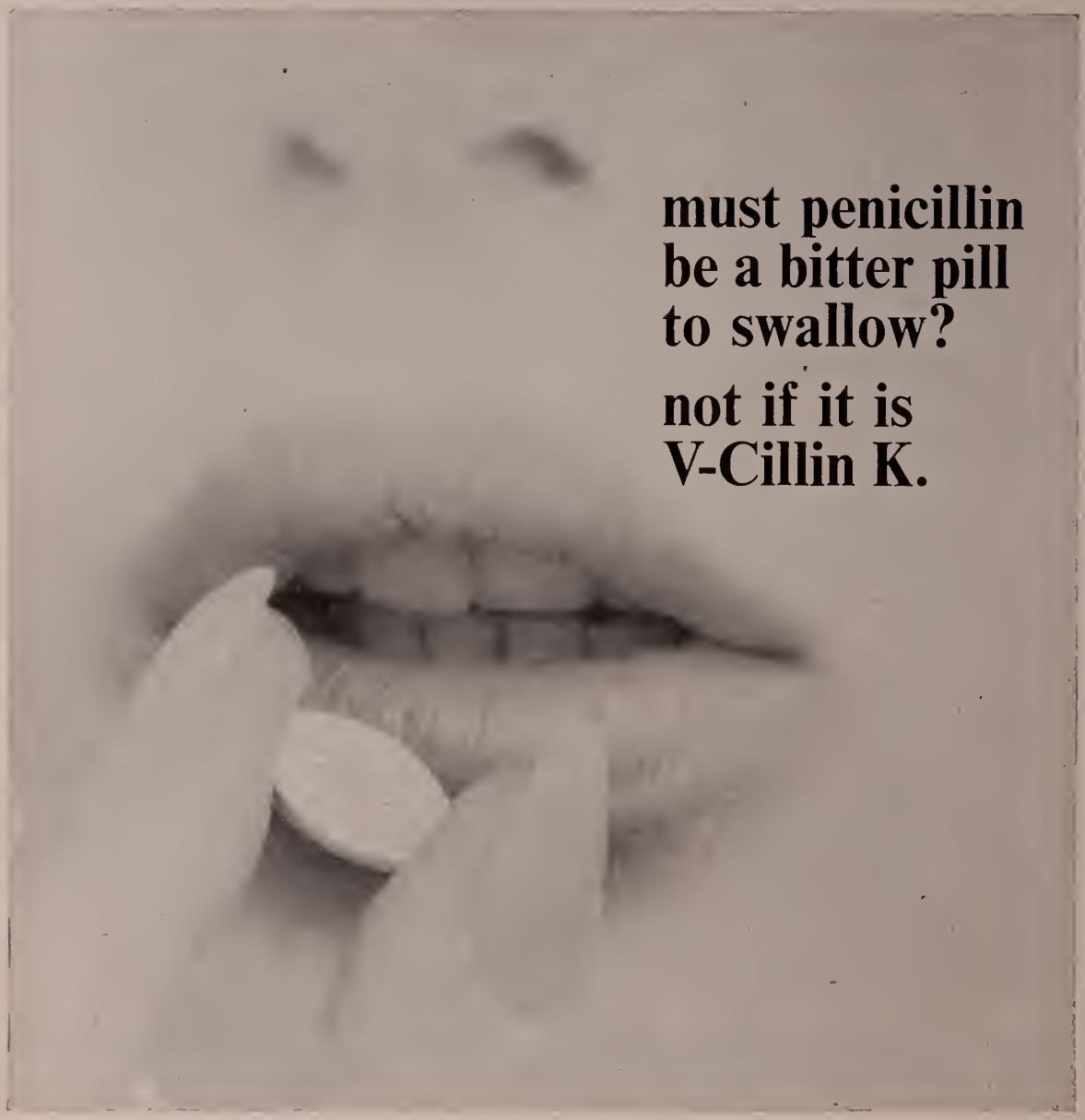
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EDITORIALS

Financial Barriers To Medical Study

Two recent studies suggest that financial difficulties play an important role in keeping promising candidates out of medical school. One survey was made by Dr. E. F. Rosinski of the Medical College of Virginia; the other by Dr. Joseph Ceithami of the School of Medicine at the University of Chicago. Dr. Rosinski first surveyed college students who had indicated aptitude for, and interest in, medical studies but who had never filed applications. He was satisfied that lack of funds to finance medical education was a major hurdle to making applications. A second, and supporting, observation was that schools with lower tuition rates attracted more applicants.

Dr. Ceithami's approach was technically different, but his conclusions were the same. He found that medical students usually have considerable trouble making ends meet financially. This tended to discourage married applicants or those with responsibility to contribute to the support of parents. This screened out many mature and responsible college students. We need, he estimated, some 9000 new M.D.'s a year in this country, but we are getting only 7500. So the gap widens every year. Foreign graduates who now fill the vacuum will soon be reduced in numbers, as the E.C.F.M.G. examinations given abroad screen out a high ratio of foreign applicants. Dr. Ceithami estimates that the average American medical student needs some $3600 a year, which must exclude many fine young men and women whose parents cannot get along if they reduce their own income by that amount. While loans are available for medical students, Dr. Ceithami suggests that the "pay back" feature makes many conscientious college students unwilling to apply. In terms of "nonrefundable financial aid," he finds that graduate students aiming at Ph.D. or D.Sc degrees in other sciences had much better luck than M.D. candidates in getting grants.

The Virginia study divided the American population into five social-economic classes. The top tier in this layering represented 3 per cent of the population, but 34 per cent of America's medical students. These are contemporary figures, based on the current decade. It is possible that 25 years ago a higher proportion of less prosperous students went to medical school. As a matter of fact, even today Dr. Rosinski's figures show that (in spite of these difficulties) some 10 or 11 per cent of the freshmen students come from the least financially favored level in the economic spectrum.

Ideally, of course, no college student with the aptitude and motivation for medical study should be turned down because of lack of funds. If proposed federal legislation is passed, scholarships of up to $2500 a year will be available to needy students. Contemplated safeguards will leave the administration of the grants (as well as of the schools) in faculty, not federal, hands. We like to think of our profession as representing an intellectual and ethical elite. But it must not become a social or financial elite, too.

William Loveridge Vroom 1866-1966

Dr. William L. Vroom's claim to a special position in our profession is not due simply to his advanced age. True, he was one of the oldest physicians in the United States at the time of his death this summer. But much more important than that, he represented in action the highest ideals of the profession. He was curious and ingenious. He constructed a workable telephone following the design developed by Bell, but adding some improvements. He was certainly the first physician in New Jersey to have a telephone and possibly one of the first to drive an automobile. He

was a friend of Woodrow Wilson and won international acclaim by delivering President Wilson's message to Villa. He was one of the first doctors in the country to use insulin and to use diphtheria antitoxin. He plunged himself into activities in Bergen County, so that he was not only the beloved doctor but he was also the good neighbor. He originated the Ridgewood Water and Sewage System. He was a founder of one of its leading banks and also of one of its first local hospitals. Dr. Vroom earned his laurels not in the laboratory but in the arena of actual help to human-beings. He was a counselor, a civic leader, a student, a teacher, a practitioner, a lover of people, a lover of life, and a lover of living. His years were many but there was much more to count in this man than years.

Another Plague Passes

The Public Health Service now says that routine typhoid inoculation is unnecessary. Even if your patient is going to a camp or entering an area where flooding has recently occured, there is no need for preventive typhoid vaccination. Foreign travel is safe if the traveller is not going to a country where typhoid fever is endemic. About the only occasion for inoculation now would seem to be intimate exposure to a known typhoid carrier and, perhaps, localized outbreaks of the disease. In 1965 there were fewer than 500 cases of typhoid fever in the whole country.

At the turn of the century, large hospitals often had special typhoid wards. Now it is hard to find a case to show to medical students. Rose spots, leukopenia, the Widal test — and something with the alliterative and catchy designation of Peyer's patches — that's how your editor recalls learning of typhoid fever in the 1920s. It was, we recall, the very first disease listed in the 1922 edition of Osler's *Medicine*.

The virtual disappearance of this plague is, of course, a tribute to medical advance — not only to the labors and attendance of the practitioner, but also to the studies and activities of our public health agencies and research installations. The conquest of typhoid is a good example of effective team work.

It's Not The Cost Per Pill That Counts

"Failure is our most important product," once said W. Furness Thompson,* speaking of the drug industry. This country's most effective drugs have been developed by trial-and-error, with the odds always being that the new idea will end in failure. Then the company cuts its losses, learns something, and starts over again. It learned something—and that is why failure has been so important.

America's ethical pharmaceutical houses plow back to research about 8 per cent of every sales dollar. Most American industries expect a pat on the back if they divert one per cent to research. With much of the drug research dead-ending in unmarketable products, the cost of this enterprise mounts. But it seems to be the only way to find that aim of all the drug houses: the pill that will.

When the citizen is paying his pharmacist's bill, he groans at the cost of the medication. But when he is sick, he demands that the industry produce for him a miracle drug—with money no object! It reminds one of the famous Rabelaisan quatrain: "The devil was sick, the devil a monk would be. The devil got well. The devil a monk was he!"

The healthy complainant talks as if the drug industry were producing medicine that cost a penny a pill and selling it at a dollar — and making it habit-forming in the bargain. But the acute killer diseases of the 19th century are now mostly conquered so that we take recovery for granted. After all, it's not the cost per pill that counts—it's the cost per spell of sickness.

* Of the Smith, Kline and French Laboratories.

ORIGINAL ARTICLES

Obturator hernia, says Dr. Dwyer, is "frequently lethal, rarely diagnosed, and surgically amenable." And here is how.

Obturator Hernia

Report of 3 Cases

William A. Dwyer, Jr., M.D./Paterson

Herniation through the obturator foramen was first described by Arnaud de Ronsil in 1724. Since then, some 550 cases have been reported, suggesting the comparative rarity of the condition. Here reported are one new and two previously unreported cases. We will also review the clinical features of this surgically amenable, frequently lethal, and rarely diagnosed entity.

Women are much more subject to obturator hernia than men (most series show a ratio of 6 females to every male). A large proportion of these hernias occur above the age of 60 (Watson[3] quotes a figure of 55 per cent of the cases he reviewed). In many cases, there is history of recent weight loss.

In the unobstructed case, there are very few definite symptoms. Transient and recurrent bouts of nausea, vomiting, and colicky pain may be noted by the patient. One symptom of diagnostic importance is described as a feeling of "numbness or cramping" along the inner aspect of the thigh radiating to the knee. This is relieved by changing position. It may also be characterized as a "dull ache." It may extend as far as the middle of the calf and occasionally even to the great toe. Known as the "Howship-Romberg sign," it is caused by pressure on the obturator nerve by the sac and its contents.

In the unobstructed case, there is usually no palpable external mass, because the sac lies beneath the adductor longus and pectineus muscles. Reports of a palpable obturator hernia are very rare. Watson,[3] however, says that when an obturator hernia is present, "a tumor or sensitive spot" can almost always be felt — by flexing, adducting, and rotating the thigh outward with the patient in the dorsal position. Occasionally, the hernia can be palpated as a tender mass on the anterior pelvic wall in the course of a vaginal or rectal examination.

In the obstructed case, the predominant symptoms are those related to the small bowel obstruction. Many give a history of illness lasting five days to a week prior to hospitalization. Yet they do not appear to have deteriorated clinically. Vomiting is not a predominant feature, as it is in the usual small bowel obstruction. This is due to the high frequency of a partial enterocele type of small bowel involvement.

In these cases, the "Howship-Romberg sign" becomes more intensified when it is present. Occasionally, putting the obturator externus muscle on the stretch by abducting and rotating the thigh inward will elicit pain in the region of the obturator foramen.

Case One

A 72-year-old woman was admitted with the complaint of abdominal distention of one week's duration. There was no associated history of abdominal pain or of vomiting. She reported that she was normally somewhat constipated but had moved her bowels since the onset of the present illness. She also stated that she had had two similar attacks in the past six months, both of which had been relieved by enemas. Apart from these attacks, her previous history was unremarkable. She was an elderly female in some distress. There was a moderate abdominal distention. There was no obvious inguinal or femoral hernia, nor any tenderness or rebound. Borborygmi were plainly heard, however. The remainder of the physical examination was essentially within normal limits.

The leucocyte count was 6,250, with no shift. X-rays of the abdomen showed multiple small bowel fluid levels.

The patient was brought to the operating room for exploratory laparotomy two days after admission, with the diagnosis of small bowel obstruction, etiology unknown. A partial enterocele of the ileum was found incarcerated in the obturator foramen. The involved loop of gut was freed from its prison with considerable difficulty by manual traction. The peritoneal defect was then closed by approximating the peritoneum surrounding it with multiple interrupted sutures. The involved portion of gut was resected and a two-layer, end-to-end open anastomosis of small bowel carried out. The patient's postoperative course was complicated by a wound infection but was otherwise uneventful. She was discharged in good condition on the tenth hospital day.

Case Two

A 76-year-old woman was admitted with a history of vomiting of one week's duration, unassociated with pain. She had moved her bowels the day of admission. She had been in good health prior to admission and had had no previous record of disease. She seemed to be in no distress, with a minimal abdominal distention. Her temperature was normal. There was no tenderness or rebound. No herniae were present. Bowel sounds were heard and seemed of normal pitch. The remainder of the physical examination was unremarkable except for moist rales at both bases.

She had a slightly elevated leucocyte count with no shift. X-rays showed "plate-like" atelectasis of both bases and multiple loops of dilated small bowel. She was first labelled as bronchopneumonia with reflex ileus. When she failed to respond to treatment, a surgical consultation was called, and the result of that was a diagnosis of small bowel obstruction, cause undetermined. At operation, a partial enterocele of the ileum was found in the left obturator canal. The incarcerated portion was forced up by traction with some difficulty. The adjacent peritoneum was utilized to close the defect. The small area of infarcted gut was inverted and the serosa approximated over it with three Lembert sutures. The patient's postoperative course was complicated by a fall, in which she fractured her hip. Despite this, she was discharged from the hospital, well and walking. She was in good condition when seen three years later, after admission for a cataract extraction.

Case Three

A 77-year-old woman came to the hospital with a history of intractable vomiting of five days' duration. She had moved her bowels the day prior to admission, but not on the day of admission. She complained of vague upper abdominal pain. A known cardiac, she was on both a digitalis preparation and diuretics. Until the onset of the present illness, she had been able to do her own shopping, cooking, and housekeeping. She had had no previous operations. She was a dehydrated-looking female in some distress, with a slightly distended abdomen. There was no tenderness or rebound. Occasional high-pitched bowel sounds were heard. There were moist rales in the right lung. Her temperature was 103 on admission. The white cell count was 5,000, with no shift. X-rays showed some dilated loops of small bowel with no fluid levels, and there was a question of a bronchopneumonic process on the admission chest film.

She was placed on wide-spectrum antibiotics with fluid replacement therapy. The day after admission she passed a moderate amount of flatus. On the second day, she became more distended, and a Levin tube was passed into her stomach. There were no specific abdominal findings except for the distention of the abdomen. She continued to complain of the upper abdominal pain, which was now cramp-like. Repeat chest x-ray showed no pulmonary pathology, and serial blood counts were all within normal limits. On the fourth day, the pain shifted to the lower abdomen. Now she was taken to the operating room, despite the dire predictions of the medical consultant. The preoperative diagnosis was probable small bowel obstruction. A partial enterocele of ileum was found strangulated and incarcerated in the obturator foramen. This loop of gut was freed from the canal by manual traction with considerable difficulty (see Figure 1).



Figure 1

Closure of the defect was effected by multiple interrupted sutures of 2-0 silk (see Figure 2). The infarcted segment of gut was resected and anastomosis effected with a one-layer closed anastomosis end to end. Her postoperative course was uneventful, and she was discharged to nursing home care on the 14th hospital day. She was well six months after surgery, when the case was reviewed.



Figure 2

The similarity in many of the previously reported cases and these three new ones is overwhelming. In the absence of an obvious cause, obturator hernia should be strongly considered in elderly women with symptoms suggesting partial or complete small bowel obstruction. The additional history of recurring bouts of cramp-like abdominal pain and of recent weight loss should double this suspicion. A careful search for the "Howship-Romberg sign" in these cases will probably result in an increased number of pre-operative diagnoses and earlier operations for this hernia. Both factors should result in a lower morbidity and mortality for this disease.

The surgeon who comes unexpectedly upon a strangulated obturator hernia soon finds himself looking for ways to enlarge the internal opening into the sac. The father of this desire for extra room is the difficulty with which the imprisoned loop of gut can be forced up by manual traction. A comparison of the loop of gut freed in Case Three with the size of the opening through which it passed gives clear idea of the problem.

However, surgical incisions into this foraminal area are fraught with the hazard of hemorrhage from either the obturator vessels themselves, or from small branches passing to the bladder or pubic bone which pass around, but close to, the foramen.

These three cases were all reduced by manual traction. This was also the method in the reported cases reviewed and should be the method employed.

Summary

One new and two previously unreported cases of obturator hernia are presented. Photographs of the hernial defect in one case are also presented. The clinical features are reviewed and a discussion of the preoperative diagnostic difficulties and operative management is presented.

The author gratefully acknowledges his indebtedness to Dr. Andrew F. McBride, Jr. for his case and to Dr. John F. Warburton, Jr. for his assistance with photography.

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Preliminary Clinical Evaluation Of A New Appetite Suppressant*

A Double-Blind Study

Harold S. Feldman, M.D., Ph.D.
Livingston

In a society conscious of the relationship between obesity, good health, and longevity many individuals want to lose weight. When weight is 15 per cent or more above normal, medical management of obesity is usually necessary to get satisfactory weight loss. Of the modalities available for obesity, the anorexigenic compounds are now the most widely used. In conjunction with a restricted caloric intake and re-education of the patient about obesity, muscular activity, and eating habits, these drugs are not only effective appetite-suppressants but also provide psychological support for the dieting patient during the initial stages of a reducing program.

In the present report, a new drug, Ro 4-5282, and placebo were evaluated for their appetite-suppressing effects. Ro 4-5282, a member of the arylalkylamine series, is chemically N- (3-chloropropyl) -delta methylphenethylamine hydrochloride.

Animal studies with this compound have shown that it is as effective as phenmetrazine in inhibiting food intake, though slightly less effective than dextro-amphetamine. When phenmetrazine was administered to rats in doses of 50 and 100 milligrams per kilogram, food intake was reduced 26 per cent and 54 per cent respectively. Ro 4-5282 in doses of 10, 20, 50, and 100 milligrams per kilogram inhibited food intake 17 per cent, 8 per cent, 36 per cent, and 53 per cent respectively. Dextro-amphetamine produced a 36 per cent and 73 per cent reduction of food intake at doses of 5 and 10 milligrams per kilogram, respectively. At these levels, animals became only mildly excited after Ro 4-5282. Marked excitation was observed after administration of phenmetrazine and dextro-amphetamine.

In preliminary clinical trials* Ro 4-5282 demonstrated appetite suppressing properties equal to those of phenmetrazine when administered in daily doses ranging from 80 to 120 milligrams. Side reactions were similar to those of phenmetrazine. In one double-blind study* with 60 obese patients, the average weight loss for patients given Ro 4-5282 was 6.7 pounds; for those given phenmetrazine, 6.4 pounds; and for placebo-treated patients, 3 pounds.

Further to evaluate the appetite-suppressing effects of this new compound in a clinical setting, 50 obese patients were selected for a double-blind study of Ro 4-5282 and placebo.

* These reports are on file with Hoffman-La Roche, Inc. of Nutley, N. J.

Material and Method

Fifty overweight patients (29 were females) were included in this study designed to evaluate the anorexigenic effects of Ro 4-5282 and placebo, utilizing a double-blind procedure. The weight range for female patients was 118 to 244 pounds; and for males, 170 to 337 pounds. Ages ranged from 30 to 66 years, although most of the patients were between 40 and 60 years of age.

In addition to obesity, 15 patients had other disorders including essential hypertension, emphysema, peptic ulcer, antral ulcer, chronic gallbladder disease, carcinoma of the larynx, albinism, and gout. Twenty-eight patients had previously received various appetite-curbing drugs including dextro-amphetamine (23 patients), dextro-amphetamine plus amobarbital (3 patients), and phenmetrazine hydrochloride (2 patients).

The population was randomly divided into two groups of 25 patients each: in the first group, tablets containing 40 milligrams of Ro 4-5282 were administered. In the second group, identically appearing placebo tablets were prescribed. The code for medications was not broken until the study was completed. Patients were instructed to take 1 tablet three times daily, a half hour before meals. Dosage was the same for all patients and remained constant throughout the study. Instructions were given for limiting caloric intake to 1,000 calories per day. Duration of treatment ranged from 3 to 7 weeks; medication was given for 3 weeks in seven patients, up to 7 weeks for one patient.

Appetites of the patients were rated prior to drug therapy and at each office visit during the study period. Patients were generally seen at weekly or biweekly intervals. Before drug therapy, appetite was rated on a 5-point scale as follows: pathologically excessive, above average, average, below average, and anorexic. In each of these categories, there were the following numbers of patients respectively: 21, 11, 15, 3, and 0 patients.

Blood count and urinalysis were done on all patients prior to therapy and during therapy, usually a month after treatment was initiated.

Over-all clinical response was rated according to the amount of weight lost, the effect of medication on appetite, the nature of side reactions, and on the emotional response of the patient. The result was rated as "excellent" if there was satisfactory weight loss plus good tolerance and patient acceptability. Those with good weight loss but disturbing side effects or poor acceptability in general were considered as "moderately improved." Those patients with unsatisfactory weight loss with or without good acceptability were put in the "ineffective" column.

Results

The over-all clinical response in patients who received Ro 4-5282 was rated as excellent in 18 patients, moderate in 5, and ineffective in two. In patients given placebo, response was rated as effective in 6 patients, moderate in 5, and ineffective in 14. These results are summarized in Table I. Statistical analysis of the differences between placebo and Ro 4-5282 ratings showed a high degree of significance. Average weight loss for the entire study period in patients with an excellent response to Ro 4-5282 or placebo was 9 pounds; in patients with a moderate response, 2 pounds; and in patients with a poor response, one pound.

A comparison of the clinical effects of Ro 4-

TABLE I
CLINICAL RESPONSE AND COMPARISON WITH PREVIOUS MEDICATION

	Over-All Clinical Response			Comparison with Previous Medication			
	Effective	Moderate	Ineffective	Better	Equal to	Less Effect.	No Previous Medication
Ro 4–5282 No. Pts.	18	5	2	3	9	3	10
Placebo No. Pts.	6	5	14	0	4	9	12

5282 with effects of previously administered anorexiants in 28 patients is also shown in Table I. Ro 4-5282 showed greater clinical effectiveness over previous medications than placebo. Twelve patients had a better or equivalent response with Ro 4-5282 as compared with former medications, whereas only 4 patients given placebo had responses equivalent to responses with previous medications.

The number of pounds lost or gained with Ro 4-5282 and placebo is given in Table II. Ro 4-5282 treated patients lost an average of 6.6 pounds per patient during the study period, and placebo-treated patients lost an average of 2.0 pounds per patients. This difference is statistically significant.

Appetite ratings given before and during therapy are summarized in Table II. Ratings given during therapy consist of an average of the total number of ratings given during the study period. Seventeen patients receiving Ro 4-5282 had a "below average" or "anorexic" rating during therapy with the drug, while only four patients receiving placebo were given these ratings.

TABLE II

SUMMARY OF POUNDS LOST OR GAINED WITH RO 4–5282 AND PLACEBO

No. pounds Lost	Ro 4–5282 No. Pts.	Placebo No. Pts.
0	2	0
0.1 to 3	4	7
3.1 to 6	5	4
6.1 to 9	7	2
9.1 to 11	3	1
11.1 to 15	1	1
15 or more	1	0
No. Pounds Gained		
0.1 to 3	1	8
3.1 to 6	1	2
TOTAL	25	25

APPETITE RATINGS BEFORE AND DURING THERAPY WITH RO 4–5282 AND PLACEBO

	Ro 4–5282		Placebo	
Appetite	Before Therapy	During Therapy	Before Therapy	During Therapy
Pathologically excessive	10	0	11	2
Above average	4	2	7	10
Average	10	6	5	9
Below average	1	10	2	2
Anorexic	0	7	0	2

TABLE III

SIDE REACTIONS IN RO 4–5282 AND PLACEBO-TREATED PATIENTS

Side Effect	Ro 4–5282 No. Pts.	Placebo No. Pts.
"Nervousness"	3	0
Dryness of mouth	2	1
Dryness of nose and lips	1	0
Insomnia	2	2
Constipation	1	1
Lightheadedness	1	0
Weakness	0	1
Tension	0	1
Leg cramps	1	0
Muscle pains	0	1
Irritability	0	1
Leg cramps	1	0
Muscle pains	0	1
Irritability	0	1

Side effects occurred in nine patients who received Ro 4-5282 and consisted of dryness of the nose, mouth and lips; constipation; leg cramps; insomnia; "nervousness;" and lightheadedness (Table III). With the exception of one patient who had insomnia and "nervousness," *all* patients reported that side effects were of a transient nature. Of the patients who received placebo, side effects occurred in 5 patients. These included insomnia, weakness, tension, constipation, irritability, muscle pains, and dryness of the mouth (Table III). All side effects disappeared with continued treatment.

No laboratory abnormalities were noted in any of the patients throughout the study.

Discussion

Under the conditions of the present study, Ro 4-5282 suppressed appetite effectively, enabling patients to lose a significantly greater amount of weight than patients given placebo: an average loss of 6.6 pounds per patient occurred in the Ro 4-5282 treated group and an average of 2 pounds per patient in the placebo-treated group. In comparison with previous medications, Ro 4-5282 was also more effective than placebo in a greater number of patients. Side effects were similar in

both the placebo- and Ro 4-5282-treated groups with the incidence somewhat lower in the placebo group. Of the six patients who reported side effects from placebo, four had previously received anorectic medications, and the side effects they reported were similar to those that commonly occur with anorexiants.

One of the problems involved in designing a clinical trial in which anorectic drugs are evaluated and patients are maintained on a restricted caloric intake relates to the duration of the evaluation period. If this period is too long, there is an increased chance that patients will slip and increase their caloric intake. On the other hand, too short an evaluation period would not permit accurate evaluation of drug effects. A period of approximately 4 weeks tends to eliminate these problems and enables a satisfactory drug evaluation to be made. The importance of the double-blind study was apparent in the present study, in which the incidence and nature of side reactions were similar with both placebo and active drug.

Initial success in the treatment of obesity is more often than not followed by treatment failure. The tendency gradually to increase daily caloric intake is very strong in most patients, and there is usually a slow but steady return to former weight levels. The problem of helping many patients achieve and *maintain* a satisfactory weight loss has yet to be solved. Once the ideal weight is reached through a gradual weight loss, periodic surveys are needed to prevent relapses. Patients should be advised that a gradual, steady weight loss is desirable rather than multiple, rapid weight losses which result from repeated, short-lived diets. Anorectic drugs may be readministered temporarily when patients find themselves slipping in their resolution to maintain a low calorie diet. Regular "check-up" visits are also important for re-educating the patient about dieting, weight plateaus, and muscular activity and for stressing the importance of regular exercise and for helping to improve patient morale.

Summary

1. Fifty obese patients ranging in weight from 118 to 337 pounds were included in a double-blind study designed to compare the anorexigenic effects of Ro 4-5282 and placebo. Dosage of the active medication was 40 milligrams three times daily.

2. Ro 4-5282-treated patients lost an average of 6.6 pounds per patient during the entire study period, and placebo-treated patients an average of 2 pounds per patient, a difference statistically significant.

3. Side effects occurred in 9 patients who received Ro 4-5282 and in 5 patients given placebo. Side effects in both groups were similar and of a transient nature in most patients.

4. Based on the results of this preliminary clinical investigation, Ro 4-5282 has significantly greater effectiveness than placebo and offers a satisfactory means of effecting weight loss in the initial stages of a dieting program.

445 South Livingston Avenue

1967 Annual Meeting

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This work suggests that, for postpartum breast engorgement, a diuretic may be safer than a hormone, and just as effective.

Value Of A Diuretic In Suppressing Breast Engorgement*

Donald R. Reisfield, M.D.
Frank L. Paret, M.D.

New Brunswick

Postpartum breast engorgement, though not a life-threatening situation, is one which takes a great deal of nursing care in the hospital following delivery. If it persists at home, it can result in numerous phone calls to the practitioner. And it is a source of anxiety to the recent parturient.

In the United States, hormonal postpartum regimens are in common use. But the numerous preparations of estrogen (alone and in combination with androgen) available to the physician would seem to suggest their lack of total effectiveness. Many studies, indeed,[7,10,12,16] do indicate a lack of benefit. Especially noteworthy is the double blind placebo series of Markin and Wolst,[16] in which the patients on the placebos rated them just as effective as the various hormone regimens tested. Other studies, however, seem to show that hormone treated patients are statistically better off than corresponding controls.† Even here, however, there are complaints of rebound engorgement and lack of 100 per cent effectiveness of the hormone preparations. In addition, lurking in the background are the unknown long range effects of random estrogen and androgen.

Many other medications have been used in an attempt to suppress breast engorgement. These include oxytocin,[11,15] clomiphene,[17] and antihistamines.[19] Of particular interest was a communication by Healy,[6] who reported the use of oral diuretics to completely suppress lactation. Utilizing Bendrofluazide (10 milligrams a day), he found *no failures in 40 consecutive patients.* Healy[6] noted no interference with uterine contractions. Since diuretics have few side actions of consequence when used over a short period of time and in ordinary dosage, it was felt that this approach merited further investigation. Therefore, this study using the diuretic hydrochlorothiazide** was undertaken to determine its effectiveness in suppressing pain and discomfort relative to breast engorgement in postpartum patients.

Materials and Methods

A double blind study utilizing hydrochlorothiazide and an identical placebo was carried out on 100 consecutive postpartum women who did not plan to nurse. Midway through the study, the drug identification was changed. We did this because the nursing staff thought they could predict, at this juncture, which pill contained the active ingredient. They made this forecast merely on their observation that one group was generally more comfortable than the other. However, at no time during the study did the obstetrical nurs-

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† These more favorable studies are listed in citations 2, 4, 5, 8, 9, 14, and 18.

** Kindly supplied by Dr. William H. Wilkinson, Merck, Sharp and Dohme Research Laboratories, West Point, Pennsylvania.

ing staff or the obstetricians know which patients were receiving the drug and which the placebo. The dosage of hydrochlorothiazide used throughout was 50 milligrams twice a day, beginning on the calendar day following delivery.

The definition of *pain* was the patient's verbalization that the breasts were painful as opposed to minor discomfort. The presence or absence of milk leakage was noted. Codeine and aspirin were used as analgesics for the relief of breast pain. The number of times the medication was asked for and on which specific days was tabulated. The necessity of ice packs applied to the breasts for pain relief was noted as was the use of any supplemental hormonal preparations. All patients were told that analgesics, ice packs, and hormones were to be freely available if desired. No restriction of fluids in either group was made since this has been shown[1] to have no effect on breast engorgement. An attempt was made to record objectively the degree of breast hardness. The presence of postpartum edema or hypertension was noted by recording the presence of ankle swelling and listing the blood pressure. The patients were generally discharged on the fifth postpartum day.

After the patient was discharged, we tabulated telephone calls about breast pain, the need to treat mastitis or breast abscesses with antibiotics, or the presence of excessive bleeding.

Results

Of the 100 patients included in the study, 90 had sufficient data tabulated to be included in this report. Of this number, 44 received the drug and 46 the placebo.

The age and parity distribution of both groups was comparable. The age distribution was 17 to 40 in the drug group, and 18 to 43 in the group receiving the placebo. Of the 44 patients receiving hydrochlorothiazide, 14 were primiparas; and 13 of the 46 in the placebo group were primiparous.

Regarding pain and discomfort (Tables I and II), *24 patients* on the drug reported 37 total days of pain and 29 patients reported 59 days of discomfort, as contrasted to the placebo

TABLE I
PATIENTS REPORTING PAIN

	Total Number of Patients	Day Post partum 1	2	3	4	5	6	7	Total days Reported
Placebo Group	35	0	3	12	25	14	1	0	55
Hydrochlorothiazide Group	24	0	1	11	14	9	1	1	37

TABLE II
PATIENTS REPORTING DISCOMFORT

	Total Number of Patients	Day Post partum 1	2	3	4	5	6	7	Total Days Reported
Placebo Group	38	0	2	21	27	20	5	0	75
Hydrochlorothiazide Group	29	1	1	18	19	15	4	1	59

TABLE III
PATIENTS REQUIRING ANALGESICS

	Total Number of Patients	Day Post partum 1	2	3	4	5	6	7	Total Days Reported
Placebo Group	26	0	2	12	18	7	1	0	40
Hydrochlorothiazide Group	16	0	1	7	11	4	2	0	25

TABLE IV
PATIENTS REQUIRING ICEPACKS

	Total Number of Patients	Day Post partum 1	2	3	4	5	6	7	Total Day Reported
Placebo Group	23	0	1	13	16	5	0	0	35
Hydrochlorothiazide Group	13	0	0	5	7	4	1	0	17

group where *35 patients* reported 55 total days of pain and 38 patients reported 75 days of discomfort. Both groups said that the fourth postpartum day was the most painful and most uncomfortable. Medication for the relief of breast pain (Table III) was utilized by *only 16 patients* receiving hydrochlorothiazide and for a total of 34 occasions and a total of 25 days, whereas the placebo group requiring medication totaled *26 patients* on 66 occasions for a total of 40 days. The drug group required an ice pack in only 13 patients on 17 days, as contrasted to the placebo group of 23 patients for a total of 35 days (Table IV.) These figures represent a statistically significant difference in the effectiveness of the diuretic at the 5% probability level.‡

The actual process of lactation and milk production is independent and is probably not affected by this medication under the conditions of this study. This is documented by the fact that 28 patients in the drug group had 55 days where milk was seen issuing from the breasts, and 38 patients in the placebo group noted this on 65 days. This is not statistically significant. The breasts were considered hard on palpation by the obstetrician in the control group on a total of 82 days. In only 6 cases were the breasts completely soft throughout the entire hospitalization. The group on diuretics had hard breasts on 74 days, and 10 patients had completely soft breasts during their entire hospitalization. Apparent was a lack of correlation between objectively hard breasts and the amount of pain experienced by the patient. This effect has also been noted by Friedman.

The numbers included in each group are insufficient to evaluate meaningfully the presence of edema and hypertension. Only one patient in each group was considered to have significant ankle edema during hospitalization. Hypertension was encountered only once. This was in a patient in the placebo group. Based on the nature of the medication, one might expect a decreased number of postpartum blood pressure elevations in a large series.

The one possible side effect which could be attributed to the medication occurred in a patient who had a caesarean section, and therefore is not included in the group reported here. Her medication had been continued for 8 days. She reported dizziness and syncope, which were relieved on cessation of the drug.

Regarding the course at home, only 8 patients on the drug reported any secondary engorgement at home as opposed to 17 of the control group. One patient in the drug group received a supplementary prescription at home for this engorgement as opposed to four receiving the placebo who were placed on supplemental hormones for attempted control of secondary engorgement. Further analgesia was required in 4 patients on drugs and 5 on the placebo.

Other telephone calls about breast discomfort where only reassurance was necessary were received from one patient in the drug group as opposed to six patients in the control group. Therefore, the amount of time spent with these complaints when patients returned home was decidedly less in the drug group. No patients developed any breast inflammation requiring antibiotic therapy.

Regarding bleeding problems, only 2 patients in the drug group had excessive bleeding requiring any oxytocics at home. Four patients in the control group had excessive bleeding requiring oxytocics. No patient in either group required curettage.

Comment

The effectiveness of a preparation in suppressing postpartum breast engorgement is difficult to evaluate. One cannot utilize breast hardness or turgor as an indicator, for this is not directly related to the pain a patient experiences. The amount of actual milk leakage is also unrelated to pain. However, it is the pain the patient experiences which is the factor that is of most concern, as pain determines

‡ We wish to thank G. Paret for statistically evaluating the data.

the number of calls to the nursing staff during hospitalization and to the physician following discharge.

Utilizing a double blind study we have established that hydrochlorothiazide is effective in controlling pain when compared to a placebo. However, it must be realized[13] that by nature of the placebo response,[20] the group on placebos also experienced pain reduction. Jones[8] found a 25 per cent success rate with a placebo alone. Therefore, the comparison of an hydrochlorothiazide group with a group receiving no placebo would have further magnified the extent of the pain reduction.

Consequently, the use of an inexpensive drug with few if any side effects to control the manifestations of postpartum breast engorgement would be a welcome addition to the armamentarium of the physician. Hydrochlorothiazide would seem to meet these requirements.

Summary

A double blind evaluation of hydrochlorothiazide in the postpartum suppression of breast engorgement reveals it to have definite value as measured by reduction of breast pain and discomfort. Consequently, there was a corresponding decrease in the patient's need for analgesia.

A full list of citations will be found in the authors' reprints.

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Dr. D'Ambrosio here tells us why he prefers thoracic aortography by direct exposure of the common carotid.

Catheterization Of The Aorta For Thoracic Aortography

Report of Three Cases

Victor D'Ambrosio, M.D./Murray Hill

Not until recently have surgeons concentrated on ways of studying diseases and anomalies of the thoracic aorta and its branches. Various methods used to visualize the thoracic aorta have occasionally given excellent results; but more often they have terminated in failure. Three of the methods tried in aortography are: angiocardiography, retrograde aortography, and direct aortography.

Angiocardiography was used for many years, primarily in the study of anomalies of the heart chambers and great vessels, especially in children. The considerable dilutions of the dye and the heavy x-ray penetration restricted the use of this method of investigation. Development of new technics for regional injection of dye also contributed to a decline in the use of this method.

Retrograde aortography was widely used before 1956. In this technic, the dye is injected through (1) the brachial artery, *via* trocar injection against blood flow; (2) the radial artery, *via* a cardiac catheter advanced into the ascending aorta; (3) the left common carotid artery, *via* a cannula inserted through an 18 gage needle; (4) the right common carotid artery, *via* a cannula inserted percutaneously into the ascending aorta; and (5) the brachial, ulnar, and femoral arteries, *via* a polyethylene catheter into the ascending aorta.

A number of disadvantages and complications are encountered in this kind of aortography. The five principal causes of failure are:

1. Insufficient amount of medium injected in the second or less — which is dependent upon the size and length of the needles and catheters.
2. Difficulties in the placement of the catheter and needles.
3. Thrombosis of small arteries used for the insertion of needles and catheter with consequent obliteration and even loss of limb.
4. Tearing of the aorta, cardiac tamponade, and ventricular fibrillation.
5. Extraversation of dye and formation of hematoma.

Because of the number of these complications, new technics were developed for injecting the dye directly into the ascending aorta or the left ventricle.

Direct aortography was done through puncture of the ascending aorta, direct puncture of the left ventricle, and intracardiac release of dye. Because of the complications listed above, the route of the right common carotid artery should be considered the safest and most effective. Certain situations, however, will lead to failure of this method. Such difficulties include congenital anomalies of the aortic arch and main branches and occlusion of the innominate artery. Some possible causes of failure in direct aortography are:

1. Double aortic arch with little or no attendant difficulties except for the presence of mediastinal mass.
2. Anomalous innominate artery-origin at an other-than-normal point in the arch. (This is difficult to pick

up when no mediastinal shadows are seen, but filling defect certainly suggests an abnormal blood vessel in the region.)

3. Dissecting aneurysm.

4. Thrombosis of the innominate artery.

In this paper, I will report on three cases of thoracic aortography in which a catheter was inserted through the right common carotid artery. This method of aortography provides constant visualization of the thoracic aorta. It appears safe; it is simple to do, and it requires only the surgical instruments and radiographic facilities which are standard in any general hospital. Rapid injection of the contrast medium into the ascending aorta at its origin eliminates many of the causes of the failures encountered when older methods are used.

Prior to catheterization, liver and kidney functions are tested, and a routine series of electrocardiograms is ordered. Tests for sensitivity to dye and procaine are made. After this, the patient is premedicated and preliminary films are taken.

Anesthesia is obtained by infiltration of 1 per cent procaine solution. The right common carotid artery is exposed through a 2-inch incision in the skin crease over the median border of the sternocleidomastoid muscle, 1 to 1½ inches above the clavicle. Two Penrose drains are passed around the artery, which is occluded by traction on the drain. Two guide sutures are passed on both sides of the area where a 3-millimeter longitudinal incision is made. Under fluoroscopic observation, a radiopaque, 35 centimeter, No. 14 French woven silk catheter (with tapered lip and a Luer-lock 50 millimeter glass syringe at the proximal end) is passed into the ascending aorta above the aortic valve.

After catheterization, 38 to 45 cubic centimeters of the 50 per cent contrast medium are manually injected into the aorta. X-ray exposure is made when 10 to 15 cubic centimeter of dye remain in the syringe. If visualization appears satisfactory on the wet film, the catheter is removed and the artery repaired with continuous 00000 arterial silk sutures. The incision in the skin is closed with silk.

Case One

A 43-year-old man was admitted to the Newark City Hospital with dyspnea, cough, and an upper respiratory infection which had been present for 5 weeks. He had a past history of typhoid fever, gonorrhea, syphilis, and pyorrhea. Until 4 years earlier, he had been a heavy drinker; and at the time of admission, was smoking 20 cigarettes a day. He was an alert, cooperative patient in mild respiratory distress. Blood pressure was 205/110. Pulse was 102. There was a pulsating mass in the right clavicular region of the neck. The thorax was symmetrical. Both lungs had coarse rales at the bases. There was a grade 2 systolic murmur over the pulmonic and aortic foci, a systolic murmur over the apex, and diastolic murmur at the base of the precordium. The liver was two finger breadths below the right costal margin.

On admission, he was given 0.4 milligrams of Cedilanid® and subsequent doses every 6 hours for three doses; plus 15 drops of potassium iodide by mouth three times daily. An electrocardiogram revealed normal sinus rhythm and left ventricular hypertrophy pattern compatible with left ventricular hypertrophy. X-ray showed the heart enlarged. Density in the right lower lungfield was suggestive of pneumonitis. Barium swallow showed the aortic shadow elongated, tortuous, and widened. There was marked left ventricular enlargement, but the left auricle was not enlarged and there was no displacement of the esophagus.

Fasting blood sugar was 83; blood urea nitrogen was 10.

Kahn test results were 4-plus reactive. Prothrombin time was 17 seconds 71 per cent; when controlled, 14 seconds 100 per cent. Bromsulphalein, 4.5 per cent retention. Thymol turbidity, 2.3 units. Cephalin flocculation test was negative. Hemoglobin was 82 per cent, 13.2 grams; white blood cell count was 11,700. The erythrocyte sedimentation rate was 55 mm per hour. Hematocrit reading was 40 per cent. The urine had a specific gravity of 1.016, with persistent albumen. Due to persistence of the swelling of the right supraclavicular region and its marked pulsation, an aortogram was done.

Blood pressure in the right arm was 140/70; on the left, it was 130/80; in the right leg, 200/90. X-ray showed prominence of the ascending aorta and ventricular hypertrophy. Injection of 40 cubic centimeters of Cardiographine® visualized the ascending aorta, the arch, and the innominate and common carotid arteries. No aneurysm was demonstrated. The patient was discharged in good condition.

Case Two

A 66-year-old man entered the Newark City Hospital because of shortness of breath and fatigue. He had been treated for chest pains for a month prior to his admission to the hospital. He had been helping to push a car when the acute chest pain began. After admission he was treated with digitalis, bed rest, and antibiotics. He had a history of syphilis, which he had contracted during World War I, and which had been treated at that time.

He was an elderly male in no acute distress. Blood pressure was 176/110. The neck showed bilateral pulsa-

tions, but no masses were palpated. Lungs were clear to percussion and ascultation. Some notching of the second and third ribs near the sternum was noted on both sides. The heart had a grade 2 systolic and diastolic murmur, which was louder over the right third inter-costal space. A diastolic murmur was present over the apex, with occasional extrasystoles. He had a reducible inguinal hernia.

Routine chest x-rays revealed an aneurysmal dilatation of the ascending aorta. Injection of 44 cubic centimeters of Cardiographine®* visualized the ascending aorta with fusiform aneurysm.

Case Three

A 63-year-old woman came into the Newark City Hospital with an admitting diagnosis of multiple fractures of the lower extremities and spine. She had been hit by a motorcycle. Upon admission she appeared confused, complaining of pain in both legs, in her right arm, along the cervical spine, and between the scapulas. She had been hypertensive for at least ten years, and had had a hysterectomy at the age of 33. Blood pressure was 180/100.

Examination of the chest showed mild contusions of soft tissue. Moist rales were present in the bases of both lungs. The heart had normal sinus rhythm; there was a grade 1 systolic murmur over the base of the precordium. Abdomen was soft. The liver was one finger below the right costal margin.

Bronchoscopic examination showed that the right middle lobe bronchi were clear. Washings were negative for tumor cells. X-rays on admission revealed widening of the aortic shadow and a right parahilic shadow, thought to be a mediastinal tumor or pneumonia, occupying the right middle lobe and medial basal segment. However, findings compatible with segmental bronchial obstruction were not revealed by bronchoscopy and bronchogram, which showed good arborization of bronchi of lower and middle lobes.

Sixty days after admission, x-rays showed disappearance of the mediastinal shadow and widening of the superior mediastinum; the ascending aorta appeared wider, more prominent, and its lateral margin was straightened.

The diagnosis of an aneurysm of the ascending aorta was considered at this time.

An attempted aortogram failed to visualize the arch of the aorta; instead, it revealed an obstruction of the origin of the innominate artery and diffuse uniform thickening of the wall, compatible with a dissection of the ascending aorta extending into the innominate artery.

Conclusions

Thoracic aortography performed *via* the direct exposure of the right common artery and the catheterization of the ascending aorta offers the following advantages:

1. Elimination of injection against the direction of the blood flow.

2. A high concentration of dye in the aorta.

3. Avoidance of thrombosis and spasm occurring when a small artery is used.

4. A simple method done under direct vision.

5. No special equipment is required.

6. Constant visualization of the thoracic aorta is obtained.

However, certain abnormalities — acquired or congenital, development or traumatic — may represent, as in case three, a cause of failure of this method of aortography. For example:

1. Thrombosis or other anomalies of the innominate artery.

2. Anomalies of the arch of the aorta.

3. Dissecting aneurysm of the ascending aorta.

While this method is recommended as simple and adequate, the physician should be alert for the anomalies described above, which contraindicate the use of this technic.

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* Furnished by Squibb Laboratories.

159 South Gate Road

A good community hospital should be able to do percutaneous renal biopsy. The value of this procedure is here illustrated.

Percutaneous Renal Biopsy*

Its Value in a Community Hospital

Edwin Kellerman, M.D./Ventnor City
Milton Ackerman, M.D./Atlantic City

Since the introduction of percutaneous renal biopsy by Iverson and Brun[1] in 1951, there has grown a considerable body of information vital to physicians who treat renal disease. It is the purpose of this paper to demonstrate the usefulness of, and indications for, this procedure in the everyday evaluation and treatment of patients in a community hospital.

Following a complete history and physical examination, with examination of the urine and urine sediment and relevant laboratory data, a decision is made concerning the necessity for a percutaneous renal biopsy. The absolute and relative containdications[2] are weighed against the possible benefit of the result of the biopsy in the management of the patient. The biopsy is usually done in the patient's room as he lies prone on a surgical cart with two sand bags under the lower chest wall. The kidney is located with reference to the patient's back by measurements from the spine and 12th rib as obtained from a KUB film or intravenous pyelogram. With the use of an oral analgesic beforehand, local anesthesia at the biopsy site, and last (but not least) the establishment of good rapport with the patient, the biopsy is usually done painlessly in a few minutes. The depth of the renal cortex from the surface of the back is determined with an eight-inch, number 22-gauge exploring needle by noting certain characteristic movements of the needle with respiration as it comes in contact with the renal cortex. The biopsy is obtained with the Franklin modified Vim-Silverman needle. Following biopsy, the patient is kept at bed rest for 24 hours of observation and is then permitted his usual activities. The safety of the procedure is related to the experience of the operator and the care in patient selection. Two recent series of cases[3,4] involving 1,000 percutaneous renal biopsies indicate no mortality and a negligible, self-limited morbidity as a result of the procedure.

Clinical Uses

1. Proteinuria of Undetermined Etiology

In patients with asymptomatic persistent proteinuria, renal biopsy is the only definitive method to determine the cause of proteinuria. It gives an indication of severity and diffusiveness of the lesion responsible. As shown by Phillipi,[5] most apparently healthy young males with this abnormality are shown to have, on renal biopsy, either glomerulonephritis or pyelonephritis. An example of a patient discovered on routine insurance examination to demonstrate persistent mild proteinuria, whose diagnosis was established by percutaneous biopsy, is presented below.

A 60-year-old male presented for an insurance examination was found to have, for the first time, proteinuria on a voided urine specimen, with a normal urine sediment. His blood pressure was 130/72. Funduscopic

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examination showed mild attenuation of the arterioles, and there was no peripheral edema. BUN was 10. Serum albumin was 5.4 with a serum globulin of 2.2. Serum cholesterol was 198. Intravenous pyelogram was normal. Following the substantiation of the proteinuria on several subsequent urinalyses, hospitalization was advised. Three 24-hour urine specimens were analyzed for total protein excretion. He excreted on successive days 490, 450, and 730 milligrams of protein. The specimen of urine obtained after overnight recumbency, to exclude orthotastic proteinuria, contained 200 milligrams per cent protein. Renal biopsy was then done. The biopsy was interpreted as showing a membranous and proliferative glomerulonephritis of minimal degree.

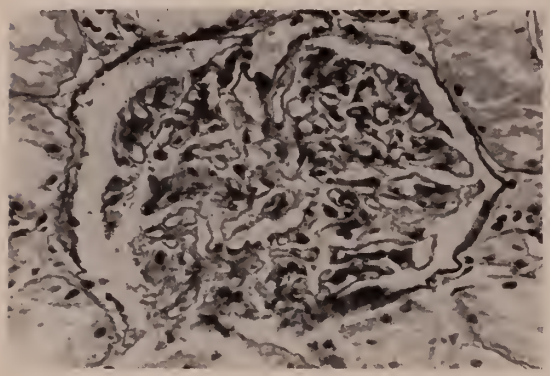


Figure 1. Membranous Glomerulonephritis

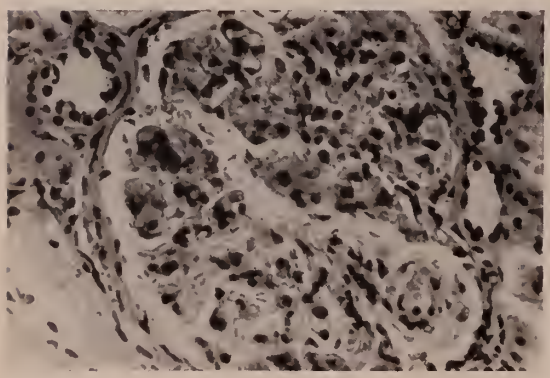


Figure 2. Proliferative and Membranous Glomerulonephritis

Establishment of a definitive diagnosis by biopsy enabled the physician to outline to the patient a rational plan of therapy to prevent further renal functional deterioration and affirmed the validity of the insurance company's assigning a special rating to the patient.

2. Renal Failure of Unknown Etiology

The clinician, not uncommonly, is faced with a patient who is suddenly found to be uremic whose symptoms may have been previously non-specific. In previous years, the determination of the acute or chronic nature of the process and its degree of reversibility was mainly a philosophical question, as only supportive medical therapy was available. However, today, with new frontiers in dialysis and transplantation, a definitive diagnosis based upon histopathology is mandatory if realistic therapy is to be undertaken. Despite a careful history and thorough physical examination, with selected laboratory and roentgenographic aids, the physician is often unable to arrive at an exact diagnosis and prognosis without the information gleaned from renal biopsy, as exemplified in the following patient.

A 52-year-old woman was admitted to the Atlantic City Hospital with a diagnosis of congestive heart failure. When her initial laboratory studies were reported, a BUN of 182 caused some surprise, as the patient had been virtually symptom-free and working daily just prior to admission. The finding of normal-sized kidneys on tomography gave some hope that the patient was not in chronic clinical end-stage renal insufficiency. However, percutaneous renal biopsy demonstrated severe, diffuse, irreversible changes of chronic renal disease.

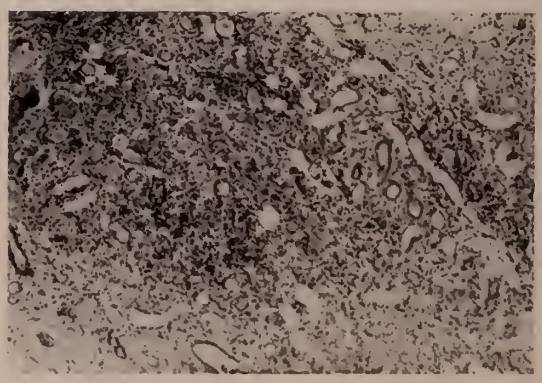


Figure 3. Advanced Pyelonephritis and Nephrosclerosis

The findings on biopsy interdicted the use of dialysis, and as a result, the patient was discharged on a sound medical program in the hope that there would be a slow progression of her chronic renal insufficiency.

3. Collagen-Vascular Diseases Including Systemic Lupus Erythematosus

Through the careful and extensive studies by Kark[8] and his group and others,[6,7] much useful information in the clinical management of patients with systemic lupus erythematosus, correlated with findings on percutaneous renal biopsy, is available. Nephritis is the most common cause of death in systemic lupus. Even with careful examination of the urine in patients with this disease, renal involvement may not be apparent except

through study of the tissue obtained from biopsy.

When renal involvement is present, anti-inflammatory agents, such as the adrenal corticosteroids, if started in adequate dosages before significant renal damage has occurred, will improve the prognosis. Some authorities follow the results of treatment by a means of serial renal biopsy. A recent patient with the features of systemic lupus erythematosus who underwent renal biopsy is presented below.

A 27-year-old woman was admitted to the hospital with weakness, myalgia, arthralgia, and fever. Two of three L.E. cell preparations were positive. There was reversal of the albumin-globulin ratio with marked hypergammaglobulinemia. Several urinalyses showed mild proteinuria with 5 to 10 white blood cells and 5 to 10 red blood cells per high power field but no casts. On percutaneous renal biopsy, a thickening of the basement membrane of the glomeruli was the predominant finding.

Despite a normal BUN and serum creatinine and absent cylinduria, definite renal pathologic changes were present which served as a focus in determining the course of the disease process and its response to therapy. It is noteworthy that in collagen-vascular diseases, the kidney is the organ which is affected most frequently.

4. Nephrotic Syndrome

Faced with a patient with the nephrotic syndrome (which may be due to a hundred different causes) the clinician can best treat the patient by knowing the pathologic process in the kidney (as demonstrated by light microscopy) responsible for the syndrome. Obviously, the finding of changes on biopsy of amyloid, diabetic glomerulosclerosis, or renal vein thrombosis would interdict the use of corticosteroids. While there is disagreement[9,10] in the literature on the response of significant membranous lesions as compared to proliferative or mixed lesions, as demonstrated by biopsy to adrenal corticosteroids, there is unanimity of opinion that when the biopsy shows only minimal changes of "lipod nephrosis," the response to corticosteroids is anticipated to be favorable. An interesting problem in this area is described below.

A 23-year-old male gave a five-day history of periorbital edema. He had had a sore throat for the past month, which was treated with antibiotics. Blood pressure was 120/80. He had normal fundi, no cardiomegaly, and no CVA tenderness or palpable masses in the abdomen. His urine showed 3-plus proteinuria with granular and hyaline casts, and red and white blood cells in the sediment, but no red blood cell casts. BUN was 36.9; the 24-hour protein excretion was 16.3. Serum albumin was 2.06 with a serum globulin of 3.84. Percutaneous renal biopsy showed an acute proliferative glomerulonephritis. Since it was felt that this lesion (because of the proliferative changes) would not respond to steroids, their use was not recommended. With supportive medical therapy and bed rest, the patient became edema-free and had a drop of his BUN to 16.5. Had steroids been used for treatment of this nephrotic syndrome, his response might have been attributed to their administration, while the threat of a serious complication of their use may have developed, as exemplified recently by a patient seen with a similar proliferative lesion who was given adrenal corticosteroids and developed a full-blown psychosis, which resolved on withdrawal of the medication.

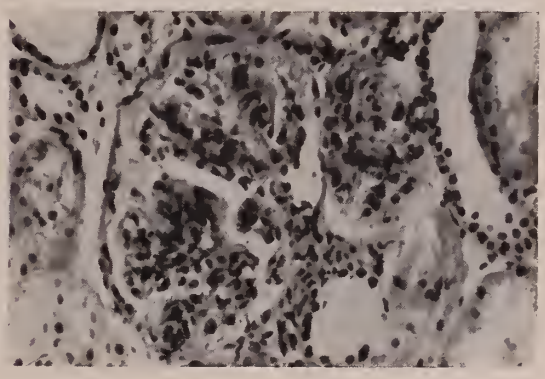


Figure 4. Proliferative Glomerulonephritis

5. Renal Hypertension

In evaluating patients with hypertension, percutaneous renal biopsy affords one means of establishing the cause of the hypertension as shown by Roland[11] who demonstrated a 39 per cent incidence of clinically unsuspected, chronic pyelonephritis or glomerulonephritis, in 70 patients with essential hypertension. In contemplating the surgical relief of hypertension (through correction of an extrarenal vascular occlusive process), the absence of intrarenal pathology as a factor in producing renal ischemia fortifies the clinician's hope that surgery will alleviate the hypertension.[12] Through the use of quantitation of juxtaglomerular cell number[13] and granularity[14] as a measure of renin production by the kidney, hopefully, a means will be available to state with some degree of certainty that the hypertension is definitely on a renal ischemic basis. The usefulness of percutaneous renal biopsy in the preoperative evaluation of a hypertensive patient with unilateral renal artery stenosis is shown below.

A 51-year-old man had severe hypertension of recent onset. Rapid minute sequence pyelography revealed delayed opacification of the left kidney and collecting system. Urea washout pyelography showed considerable delay in "washout" of dye from the left kidney

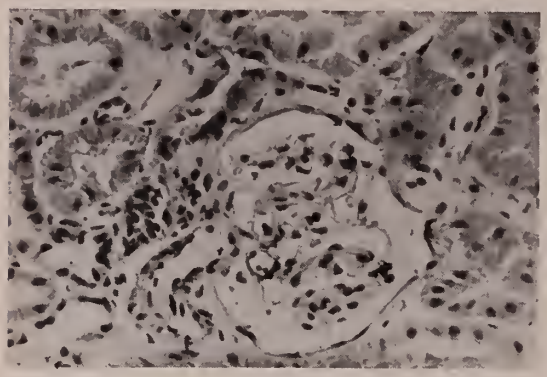


Figure 5. Normal Glomeruls with Juxtaglomerular Apparatus

and collecting system, implicating the left kidney as being functionally responsible for the hypertension. Renal arteriography demonstrated a localized occlusion in the proximal left renal artery. Split renal function studies with bilateral ureteral catheterization demonstrated a classical pattern of renal ischemia, with decreased glomerular filtration rate and renal blood flow, with increased water and sodium reabsorption in the left kidney. Percutaneous renal biopsy provided tissue which showed normal renal architecture.

The absence of intrarenal ischemic changes in the left kidney (which functionally appeared to be responsible for the patient's hypertension) fortified the medical decision to proceed with a revascularization procedure for the left kidney in an attempt to remedy, surgically, the patient's hypertension.

Summary

Percutaneous renal biopsy in certain situations will provide the physician with information which enables him properly to manage and treat his patients. While the indications for renal biopsy have been firmly established, great hope is held that, in future clinical-pathologic correlations established by this procedure, better means of therapy will result. This should prolong useful, productive, and happy life for those afflicted with renal disease.

A list of citations appears in the authors' reprints.

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Animal Research in Danger

The "animal protectionist" groups have mounted the greatest offensive against the effective use of animals in biological research and teaching that has ever been attempted in the United States. Today in Congress there are bills to which about 40 congressmen have attached their names, dealing with procurement, housing, care, and use of experimental animals. The present mood of Congress is to accede to the demands of the vocal animal protectionist minority and pass some sort of legislation. Every physician and biological scientist who has a sense of public responsibility should be informed of the issue and communicate his views to his congressman as to public harm that might be done by unwise legislation.—Maurice B. Visscher, Ph.D., M.D., in *Modern Medicine,* (34:87), March 14, 1966.

Who Makes the Drugs We Prescribe?

Tradenames usually are more easily identified and remembered than generic but have the disadvantage that the same drug appears under a variety of tradenames. Usually the physician sticks to the name he remembers and the company he trusts. Are trademarked drugs more reliable? In general, yes. Generic name use tends to encourage the fly-by-night manufacturer who occasionally sells drugs for legitimate use through the front door and to the rackets through the back. I would rather pay more for a tradenamed amphetamine than a cheaper tablet which may largely participate in the goofball market. And then there are drugs, such as digitalis, that I would not dare use without knowing who made them.—Irvine H. Page, M.D., in *Modern Medicine,* (34:104), June 6, 1966.

The earliest stage at which diabetes can be diagnosed is the "latent" phase. Dr. Haynes here offers some clues to such a diagnosis in patients with no frank diabetic symptoms.

Clues To The Detection Of Latent Diabetes

William F. Haynes, Jr., M.D./Princeton

The "complications" of diabetes mellitus can occur *before* the characteristic findings of hyperglycemia and glycosuria.[1] Diabetes is now viewed[2] as a genetically determined disease, recessively transmitted, with the defect present from the time of conception. When frank diabetes becomes clinically evident, it may be regarded as the unsuccessful conclusion of a subclinical struggle between certain diabetogenic forces and the body's insulin-producing beta cells of the pancreas. Hence, diabetes can be categorized into various "stages;" i.e., prediabetes, latent (or chemical) diabetes, and frank diabetes. Each stage is merely a step along the continuous pathway of the same basic disease.

Prediabetes is the asymptomatic phase of the disease in which the glucose tolerance test is normal. It is only a concept, as there is no clinical way of making the diagnosis. A diagnosis of prediabetes can be made with reasonable certainty only when both parents are diabetic or when an identical twin is diabetic.[3]

Latent diabetes is the phase just short of frank diabetes. The patient is asymptomatic but does have an impaired glucose tolerance curve. As this is the earliest phase in which diabetes can be definitely diagnosed, and as it is a stage in which the course of the disease can frequently be altered, any clues which can aid the clinician in making the diagnosis of latent diabetes are worthy of mention.

The purpose of this paper is to suggest clues present in the history, physical examination, or laboratory which were helpful in making the diagnosis of *latent* diabetes in clinical practice.

One hundred and ten patients from the author's private practice were diagnosed as having latent diabetes between June 1962 and June 1965, and form the basis for this study. Of these, fifty-one were female. Their ages ranged from 14 years to 83 years, with a mean age of 46 years.

All patients underwent a standard three-hour oral glucose tolerance test. Three days before this, each patient was placed on a diet containing at least 300 grams of glucose. The test was done in the morning in the fasting state. Blood glucose determinations were obtained in the fasting state and at one-half, one, two, and three hours after the ingestion of glucose. A urine specimen was obtained with each blood specimen. A "diabetic curve" consisted of blood glucose values of 160 milligrams per cent or higher at one hour; 120 milligrams or higher at two hours; and 110 milligrams or higher at three hours.[4,5] Determinations were by the Somogyi-Nelson method. We also did a urinalysis, serum cholesterol, and uric acid.

Cardiac Dysfunction

The most common organ afflicted among these *latent* diabetics was the heart. Thirty per cent demonstrated significant abnormalities in this area. Twelve men and three women

had suffered one or more myocardial infarctions. Nine males and five females had dysrhythmias, which included bouts of paroxysmal supraventricular tachycardia, runs of ventricular extrasystoles, and marked sinus bradycardia. The serum cholesterol was 250 milligrams per cent or greater in twelve of eighteen males with heart disease and elevated in seven out of ten female patients with heart disease. It was not measured in five patients with heart disease. (See Table 3)

TABLE 1
HELPFUL CLUES TO THE DIAGNOSIS OF LATENT DIABETES MELLITUS AMONG 110 PATIENTS

	Males	*Females*	*Total*
I. *History*			
Cardiac dysfunction	22	11	33
Positive family history of diabetes mellitus	11	19	30
Repeated infections	5	8	13
History of gall stones	3	9	12
Peripheral vascular disease	7	5	12
Symptoms of hypoglycemia	2	2	4
Large babies	0	4	4
Persistent diarrhea	1	2	3
Sterility	0	2	2
Multiple miscarriages	0	1	1
Impotency	1	0	1
II. *Physical Examination*			
Moderate obesity (15–25 lbs.)	21	14	35
Marked obesity (25+ lbs.)	3	3	6
Prematurely aged appearance	4	2	6
Xanthalasma	1	2	3
Cataracts	1	0	1
III. *Laboratory*			
Elevated cholesterol	33	18	51
Elevated cholesterol as only clue	16	12	28
Stress glycosuria (transient)	7	7	14
Elevated uric acid	7	0	7

TABLE 2
MANAGEMENT OF 110 LATENT DIABETICS

	Males	*Females*	*Total*
Insulin	0	0	0
Sulfonylurea drugs	10	16	26
Weight reduction	24	17	41

TABLE 3
LATENT DIABETICS WITH HEART DISEASE

	Males	*Females*	*Total*
Myocardial infarction	12	3	15
Angina	9	5	14
Dysrhythmia	1	3	4
			33

Positive Family History of Diabetes Mellitus

The family history was considered positive whenever grandparents, parents, or siblings were known to have diabetes mellitus. With this in mind, only thirty of our 110 latent diabetics had a positive history.

Repeated Infections

Repeated boils led to the consideration of latent diabetes in four males. Recurrent urinary tract infections were found in four females and one male. Four females were found to have repeated respiratory tract infections.

Gall Bladder Disease

Many diabetics and latent diabetics have an elevated serum cholesterol. Since gallstones are composed of varying amounts of cholesterol, it was not surprising to find a significant history of cholecystitis and cholelithiasis in these patients. Nine females and three males were so afflicted, and this served as a clue to considering latent diabetes mellitus.

Cerebral and Peripheral Vascular Disease

Two males suffered from strokes, one at age 41 and one at 50. Both had an elevated serum cholesterol. One female had a stroke at age 41. She, too, had an elevated cholesterol. Claudication was found in three males and two females. Poor healing of stasis ulcers with diminished pedal pulses were found in one male and one female.

Hypoglycemia Symptoms

Four patients suffered from the typical hypoglycemia symptoms of irritability, giddiness, palpitations, weakness, and hunger three to five hours after meals. All were found to have diabetic glucose tolerance curves.

Obesity

Patients who were twenty-five pounds or more overweight were considered to be "markedly" obese. Three males and three females were in

this category. Patients fifteen to twenty-five pounds overweight were considered to be "moderately" overweight. Twenty-one males and fourteen females were in this group. Obesity in one form or another was found in 37 per cent of all patients in the study.

Serum Cholesterol

The most significant laboratory clue to the diagnosis of *latent* diabetes was an elevated serum cholesterol. This was found in 60 per cent of all the patients. It was the sole clue in over 27 per cent of the patients.

The routine blood sugar was found to be virtually useless for detecting *latent* diabetes mellitus. The serum cholesterol, on the other hand, was found useful in routine check-ups for highlighting potential cardiovascular disease as well as the possibility of latent diabetes. As a corollary, all patients demonstrating the signs or symptoms of coronary, peripheral, or cerebral atherosclerosis at a young age, and asymptomatic individuals with an elevated serum cholesterol, should have a three-hour oral glucose tolerance test to rule out latent diabetes mellitus. The correlation between heart disease[6] and serum cholesterol has been noted by others.[7] Others[8] have noted a correlation between an elevated uric acid and latent diabetes mellitus. The serum uric acid was measured in 35 patients and was found to be normal in 28. It was elevated in seven males. Hence, only seven of thirty-five patients with latent diabetes had an elevated uric acid. This suggests that a greater ratio of latent diabetics will demonstrate hypercholesterolemia rather than hyperuricemia.

Various transient stresses evoked a transient glycosuria. Among the stresses were two strokes, four acute infections, and three pregnancies. The urines frequently were negative, even during the stress, and all reverted to normal following the stress.

Management

Once the diagnosis of latent diabetes was made, every patient tested his urine before every meal and at bedtime for one week, keeping a careful record of any glycosuria. If no glycosuria was detected, management consisted simply of avoiding excess carbohydrates and achieving an ideal weight. A sulfonylurea drug was used only when glycosuria was detected and in such dosage necessary to keep the urines free of sugar. Ten males and sixteen females were placed on one of the sulfonylurea drugs. None were placed on insulin therapy.

Whether taking a sulfonylurea drug or not, all patients were instructed to test their urine at bedtime two times per month for life. A fasting blood sugar was done every six months to one year. Under this program, any islet-cell exhaustion should be detected before the appearance of the typical symptoms of frank diabetes mellitus. It should be of interest to note how many of these latent diabetics develop frank diabetes over the subsequent years ahead.

Conclusion

One hundred and ten patients over a three-year-period were diagnosed as having *latent* diabetes mellitus. There were fifty-nine males and fifty-one females. All were drawn from the author's private practice. All patients had a positive three-hour oral glucose tolerance test. Certain clues were found useful in considering the diagnosis. Thirty per cent suffered from cardiac disease. Twenty-seven per cent had a positive family history of diabetes. Other important clues to the diagnosis of latent diabetes included recurrent bacterial infections, gall bladder disease, cerebral and peripheral vascular disease, hypoglycemia symptoms, and obesity. An elevated serum cholesterol was an extremely important clue found in 60 per cent of all patients. It was the only clue in 27 per cent of the patients. It was also elevated in 70 per cent of patients with heart complications. Serum uric acid was rarely elevated. This was in sharp contrast to the much larger ratio of latent diabetics with an elevated serum cholesterol.

It was found necessary to place 25 per cent of the patients on sulfonylurea drugs to control transient glycosuria. All were put on a diet

avoiding excess carbohydrates. Obese patients were placed on weight reduction programs. No patients were given insulin. The number of latent diabetics in this study that ultimately become "frank" diabetics may give an insight into the natural history of this disease. It is hoped that early recognition and appropriate treatment of latent diabetes may alter the course of the disease and minimize future complications.

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This is the second of a series of articles on workmen's compensation and industrial rehabilitation in our state.

Rehabilitation Of The Disabled Worker

Litigation as a Barrier to Rehabilitation*

Jarvis Smith, M.D./Trenton

The issues which give rise to litigation requiring administrative or judicial decision in Workmen's Compensation cases are grouped into two broad categories. The first includes controversial issues normally raised by the employer or carrier which relate to the liability of the employer. The second broad category relates to the whole question of the nature and extent of the disability. For many years, the Workmen's Compensation Division did almost nothing in the way of supervising direct settlements. It did not take into consideration the welfare of the worker and whether he was getting the correct amount when his employer settled the case. Consequently, the astute workman found it to his advantage to secure a lawyer and to prosecute his case at the formal level. The ardent prosecution of cases tended to establish standards by which the cases were handled and settled, and this has led to decisional progress in improving the scope and coverage of the law. All this can be attributed to the precedent effort of the claimants' attorney.

Possible Effects of Litigation on Rehabilitation

But there are difficulties created by litigation. Excessive litigation inhibits the rehabilitation process. Rehabilitation is most successful when it starts early in the course of disability with "first aid" in the case of injury. Delays in starting rehabilitation prolong recovery and limit extent.

The litigation settlement frequently guarantees that a delay will take place. The law in New Jersey provides that an award on permanent disability (total or partial) need not be made until 26 weeks after either the accident, the final act of medical treatment, or the employee's return to work. This delay, until the injury stabilizes, is worthwhile in avoiding premature assessments of disability but it may be disastrous if it delays the rehabilitation process.

Delay is not the only obstacle. Dr. Leon Lewis, in a paper entitled "The Social Dynamics in Medical Aspects of Workmen's Compensation," pointed out that the difficulty is that the context of medical care becomes forensic rather than clinical. "There is a tendency for diagnosis, therapy, and prognosis to be formulated with the future hearing in mind," he said, "rather than the return of the claimant to productive employment." Dr. Lewis noted that it may be necessary to unfreeze the pattern of law which has saddled this country with a system designed for a simple injury and short-time disability but not able to serve the seriously disabled who require a multiplicity of services for adequate restoration.

A third possible deterrent is that litigation may tend to encourage the worker to demonstrate the maximum amount of his dependence until the claim has been settled. The

* An abstract by Jarvis M. Smith, M.D. — Medical Director, New Jersey Rehabilitation Commission — from the original monograph by Monroe Berkowitz, Ph.D.

American Public Health Association points out that since the claimant must prove disability he tends to believe in it himself.

Some have argued that it is not feasible to graft onto an essentially forensic system a rehabilitation consciousness. This, surely is a counsel of despair. The thinking of the Institute's panel devoted to this topic was not so pessimistic. It was felt that many things could be done, given the existing framework, to achieve the goal of rehabilitating the worker and restoring him to the maximum physical, economic, and social usefulness to which he is capable.

When Liability Is Questioned

In dealing with these problems, the Michigan Workmen's Compensation-Rehabilitation Conference recommended that in cases where there is a "color of right," the rehabilitation of the worker should begin immediately, if it is indicated, regardless of the eventual fixing of liability. It was also felt that the rehabilitation program should be under the supervision of the Workmen's Compensation Agency. Our panel thought there might be alternative solutions in New Jersey. It was recognized, for example, that one way to minimize the effects of these cases is to see to it that any disputes about liability or casual relationship are promptly heard.

The Rehabilitation Commission, in appropriate cases, stands ready to provide medical care. In this respect the panel urged the Legislature to appropriate sufficient monies to the Rehabilitation Commission so that it can afford the maximum services to the injured workmen. In cases where the Rehabilitation Commission does provide medical care, if the carrier or employers are eventually liable, they would be expected to reimburse the Commission for the outlays. The position of the Rehabilitation Commission in cases of this sort is not widely understood, and it was recommended that publicity be given to it so that the facilities of the Commission can be more fully utilized in appropriate cases.

TDI Versus Workmen's Compensation

New Jersey is fortunate in being one of four states which has a program of Temporary Disability Insurance, or TDI. This provides weekly cash benefits to employees who are disabled by reason of illness or non-work connected injuries. A disabled worker should find himself entitled to Temporary Disability payments either from TDI or Workmen's compensation. However, it is an irony of our fractionated approach to the social insurances that, at times, a worker may find himself between the two agencies as it were and be unable to collect from either program because of doubt as to which program should pay him. There is a definite need for immediate clarification of this situation; and in doubtful cases where compensation liability is in question, the worker should be able to receive TDI benefits.

The Role of the Attorney

In the view of the institute's panel, litigation can be an aid to rehabilitation when the client has an advisor in whom he has confidence. If the lawyer gives proper advice as to the desirability of submitting to rehabilitation, this may overcome whatever reticence the worker may have to accept such a program. It is the nature of compensation practice that attorneys find it profitable only if they specialize in it. In the opinion of the panel, the specialist in Workmen's Compensation should be prepared to do all he can to enhance his client's progress toward medical and vocational rehabilitation. In our state attorneys' fees for handling Workmen's Compensation matters are strictly governed by the judgment of the Division. No attorney may accept a fee other than that allowed to him by the Division. Obviously this close control of attorneys' fees can be adopted as a sanction against attorneys who do not represent their clients to the best and fullest degree. This would include not only their representatives in securing maximum case awards but also in representing their interests insofar as rehabilitation is concerned.

The attorney to whom a worker comes for advice on Workmen's Compensation is in a strategic position. If medical treatment is needed (or if a rehabilitation process should begin) he is in a position of trust and confidence and his advice to the worker is likely to be followed. The panel agreed that some lawyers file claim petitions without first obtaining the medical reports. This may be advisable from the point of view of protecting the employee's legal interests, but it may be detrimental to efforts toward his eventual restoration to the job. The panel agreed that a rule should prohibit the filing of any petition (except under unusual circumstances such as the running of the statute of limitations) unless medical information has been obtained beforehand by the attorney.

Exchange of Medical Information

It is recommended that changes be made to assure pre-exchange of medical information. Specifically, on the request of the petitioners' attorneys, reports relating to the medical treatment of the injured worker should be provided by the carrier as a matter of right. The committee recommended that the carriers have the same access to information in custody of the injured worker's present physician or attorney. This free exchange of medical information at an early stage of the process might do much to eliminate dispute and to minimize whatever deleterious effects the litigation process might have on the rehabilitation potentials of the worker.

The Disabled Puerto Rican Worker

A special problem is posed by the rehabilitation of the industrially disabled Puerto Rican worker who has emigrated as a permanent worker or who is temporarily employed under contract. The Institute's panel agreed that all parties to the process should lend efforts to facilitating the medical examinations of the petitioners for treatment for trial purposes within the Commonwealth or within New Jersey. Where necessary, the State Insurance Fund of Puerto Rico should defray transportation expenses for an injured client under such circumstances with the right to reimbursement under law (through an amendment of the statute) upon successful completion of the trial. In certain hearing centers, the Commonwealth of Puerto Rico, through its representatives, has agreed to provide the Division with qualified interpreters. It was recommended that the Division of Workmen's Compensation fully utilize such personnel.

Workers' Incentive

The incentive of the worker is the essential ingredient in the process of rehabilitation. The worker who may become discouraged, who may be maximizing his disability to the point where he has become dependent, is not a good candidate for rehabilitation. Even apart from these considerations real problems are presented when workers are unable to undertake a particular training program or regimen of physical rehabilitation because of lack of cash income. The recommendation was that temporary disability payments should be continued while the claimant is undergoing medical and vocational rehabilitation services and while undergoing training.

Recommendations and Findings

1. Litigation need not be a barrier to rehabilitation.

2. Petitioners' attorneys have made a valuable contribution in the field of decisional law.

3. To encourage a positive attitude on the part of lawyers toward the rehabilitation process, legal fees should be computed so that they have the best possible effect on the provisions of medical and rehabilitation services.

4. The formal method of settling cases will have more meaning if it is reserved for cases where it is indicated.

5. The free exchange of medical information can reduce the issues that are subject to litigation.

6. There is an immediate and definite need for the Department of Labor & Industry to clarify the situation where liability is con-

tested in a Workmen's Compensation case and the employee is not receiving temporary disability benefits.

7. Insofar as the provision of medical care and rehabilitation services are concerned — in cases where liability is contested, all parties should be apprised of the position of the Rehabilitation Commission which stands ready to make available facilities of the Commission for necessary services in appropriate cases.

8. If there is any question of liability of the employer, motions for temporary disability and medical treatment should be handled expeditiously by the Division.

9. A successful program of rehabilitation requires a consciousness of the problem among all concerned, including employees of the Rehabilitation Commission and Workmen's Compensation Division.

10. Temporary disability payments should be continued to the claimant while he is undergoing medical and vocational rehabilitation services.

11. The Puerto Rican resident who comes to work in New Jersey either as an emigrant or a contract laborer, poses special problems in Workmen's Compensation. Where necessary, the State Insurance Fund of Puerto Rico should defray transportation expenses for an injured client, with the right of reimbursement (through amendment of the statute) upon successful competition of the trial.

If this article, or any of the series, stimulates questions, they should be sent to Jarvis M. Smith, M.D., Medical Director, New Jersey Rehabilitation Commission, John Fitch Plaza, Trenton, New Jersey 08625. At the conclusion of the series, Dr. Smith will answer such questions in THE JOURNAL.

John Fitch Plaza

We Passed The 4 Million Mark: But Don't Cheer

For the first time in history, we passed the 4 million mark: 4 million people injured or killed in automobile accidents in 1965. This bleak message is reflected in the Travelers Insurance Companies' annual highway accident booklet, which reports 48,500 deaths and 4,100,000 people injured last year. Statistics were compiled from reports by state motor vehicle departments. Fatalities had increased by one per cent over 1964; injuries were up by seven per cent.

Young drivers—those under 25 years of age—again led the list of offenders. And their collective record in 1965 was substantially worse than in any previous year.

These younger persons represent only about 18 per cent of all licensed drivers; they were involved in more that 30 per cent of all fatal accidents and 28 per cent of all non-fatal ones. "Sooner or later," says a Travelers spokesman, "the traffic toll will reach proportions where the nation will no longer tolerate such destruction on the highways." Travelers is sponsoring a massive research program to study man and his environment. The first phase of this deals with man and the automobile and studies the interaction of the driver, the car, and the environment.

Travelers already has invested $250,000 in this study and expects to contribute thousands more as research continues.

For your copy of this brochure,* write to Public Information Director, Travelers' Insurance Company, 1 Tower Square, Hartford, Connecticut.

* Ask for *You Bet Your Life: 1965.*

To the engineer, the human circulatory system may be a simple hydraulic mechanism. Fortunately, to doctors, it is much more than that.

Blood Pressure: A Problem In Hydraulic Engineering

Arthur R. Harmon/Port Republic

The human circulatory system is not a supernatural phenomenon. It is a fundamental mechanical system, answering to all the laws of physics and mechanics. And with no knowledge of medicine whatever, the engineer can re-design the human circulatory system to meet all the conditions which will arise in the operation of the human body; can tell you how it *must* operate, and why it will perform in a certain manner. Let me now outline the circulatory system as it appears to the engineer. It does not assume any empirical knowledge of medicine. It is offered only as a mechanical discussion of what must take place in the circulation of fluid in ducts.

The circulatory system is not a complicated one. It has only one basic purpose: to distribute blood to all parts of the body. Blood is a relatively noncompressible fluid which reacts to natural laws just as any other fluid does. There are, therefore, certain principles which must hold good for this system just as they do for any other pumping project. Ducts will be needed to direct the flow of the fluid; a pump will be required to move it against the resistance to flow which it will encounter; valves will be needed to keep the flow always moving in the right direction. With resistance to flow, mechanical force will be necessary to cause the fluid to move; and mechanical force acting on the fluid will generate hydraulic pressure. And there will be problems extraneous to the actual pumping system which will gravely affect its functioning. All these things must be considered by the designer who would re-create the human circulatory system. These problems have been met and solved by the medium of trial and error in the body over many millions of years, and the results are only what must be, only what meets with all the basic laws of physics and mechanics.

To arrive at a correct design, specifications are required to take into consideration not only the needs of the system but also its environment, the external forces acting on it. And there must be consideration of building materials, and types of pumps and valves. A closed system is required to prevent loss of fluid and to keep impurities out of the fluid stream; there can be no open reservoirs to spill over or to catch dirt. A pump is needed to maintain the flow of fluid. The ducts must be tough but extremely flexible. Since the human body is a moving, elastic thing, the system must be able to resist the stresses placed on it by the flexing or pressure of the body, or of forces external even to the body. And the strictures on building materials are severe.

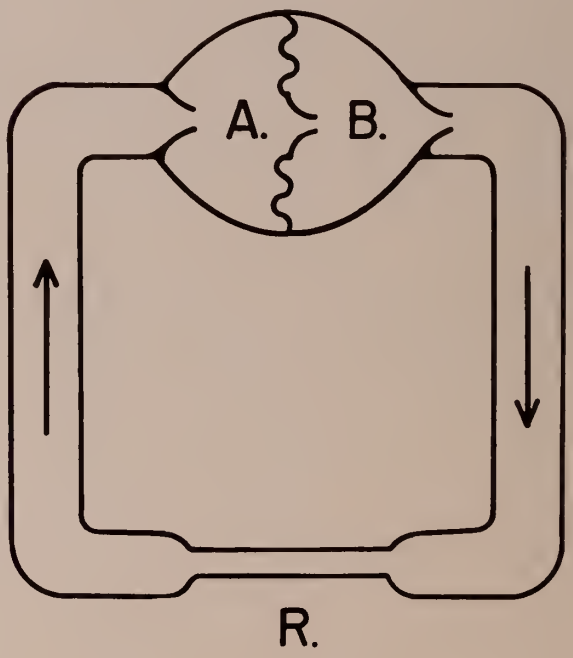
Nature builds with small blocks. Each cell is a self-energized living creature. Nature combines many millions of these cells to form a plastic material which is strong, flexible, elastic, self-energizing, and self-repairing. Man cannot duplicate it synthetically and the body cannot produce anything else, so we take it as it is, and consider it for our building material. Besides, it meets all the needs imposed on it — and meets them efficiently — so we could probably find no better substance. Ducts, valves, and the pump itself will be constructed from it.

Material restrictions dictate a diaphragm pump, and good design would indicate the same thing as being the simplest, most trouble-free type of pump possible. Material restrictions dictate a flapper type valve; and again, this is the simplest and most trouble-free valve we know. The available material is ideal for the ducts; nothing could perform better than this jointless, seamless, plastic tubing.

But what form will the pump take? There are several variations of the diaphragm pump. The simplest is the "squeeze-bulb" of the common atomizer. This has a check valve in each end to keep the fluid (air) flowing in the proper direction. Could we use the squeeze-bulb for a pump, with our self-energizing plastic alternately contracting and expanding the bulb? No, definitely not; for we must have a closed system, with no external reservoir, with the fluid flowing from the outlet of the pump through ducts back to the inlet of the pump. The volume of the squeeze-bulb alternately increases and decreases; and since liquid is not compressible, then the ducts would have to contract and expand proportionately to allow room for the displaced fluid. Such expansion of the ducts would cause serious disturbances to the system, so the squeeze-bulb would be rejected for this reason alone. And it has other drawbacks. The rib cage in which it must be located is a rather yielding framework. As the bulb must alternately contract and expand in order to pump, it must move the chest wall to get the room, or displace some other body equipment. But what if the body is temporarily crowded, or jammed? Then the bulb cannot expand, and circulation will stop. Remember that the system cannot fail to operate, even momentarily, without disastrous results. If any animals, down through the ages, were born with hearts like the squeeze-bulb, they did not long survive the vicissitudes of life.

There is still another objection to the squeeze-bulb type of pump. The circulatory system must be supercharged to a pressure above that of the surrounding air. Why such a system pressure is necessary and how it is maintained will be considered later; suffice it to say that the squeeze-bulb would have to work not only against the resistance to flow of the fluid stream but also against this system pressure, imposing a load on it which is not necessary and which can be avoided by proper design.

The circulating system, then, must be designed so that the fluid flow occurs without appreciable change of volume of pump or ducts, and system pressure must be balanced out. Both of these problems are encountered in industry, and pumps have been designed just to overcome them. One such pump is the double-chamber, single-acting reciprocating type, and it can be modified to fit the materials we have to work with; can be made as a diaphragm pump. It is illustrated in the diagram pictured below.



Like the squeeze-bulb, this pump is a chamber with check valves in each end. Unlike the squeeze-bulb, it remains constantly distended, held that way by the internal system pressure previously referred to. Dividing the bulb into two chambers is a diaphragm, and there is a third check valve built into its face. Here the advantage of our self-energizing plastic is ap-

parent; for, with no outside source of power, this diaphragm can flex back and forth in the bulb entirely under its own power, supplying the energy needed to force the fluid through the ducts against the resistance to flow. When it moves to the left, the fluid in chamber A flows through the check valve in the diaphragm into chamber B, since it cannot flow back into the inlet duct because of the check valve in that line. During this stroke there is no circulation of fluid in the ducts. But when the diaphragm moves back to the right, the fluid, now blocked by the check valve in the diaphragm, must move into the outlet duct, forcing the liquid already in the ducts back into chamber A. Thus one cycle of the pump causes an intermittent flow of liquid in the ducts, accounting for the pulse we feel in our wrist.

In this cycle there has been no change in the volume of the bulb, because as the diaphragm moves it simply transfers fluid from one chamber of the bulb to the other, and consequently there is no change in the amount of fluid in the bulb, and likewise no change of volume in the ducts. This is a closed system which pumps fluid without any change of volume in any of its parts. It can be distorted or subjected to minor external forces without interference with the pumping or circulating action. It is practically jam-proof.

Let's study the diagram for a bit. It indicates a very elementary system. There is the pump, an inlet duct bringing fluid into the pump, an outlet duct carrying fluid away from the pump, and a single small connecting duct to transfer the fluid from the outlet back to the inlet. The fact that the human circulatory system has ducts which branch out indefinitely into minute capillary tubes does not change the basic flow pattern, and our diagram contains all the elements needed for a study of this flow. In fact we can consider all resistance to flow as being offered by that one small duct shown. Resistance to flow naturally implies that fluid is moving. When motion ceases, resistance ceases; as speed of flow increases, the resistance, or drag, increases likewise. To overcome that drag, force must be applied to the liquid, and that force is applied by the moving diaphragm. When a mechanical force is applied to a liquid, pressure is generated. The pump creates pressure in the system between itself and the resistance, and then the pressure is dissipated as its force is used up in overcoming resistance to flow.

But superimposed on this pumping pressure is a system pressure. For the time being, consider our closed system as an automobile inner tube, inflated to a pressure above that of the atmosphere. Then with the diaphragm at rest, the pressure would be the same in all parts of the system, both in the ducts and in the pump, and the pressure would act on both sides of the diaphragm equally. If this internal system pressure does not distort the ducts, or change their diameter, there will be no change in the resistance to flow of the fluid, no matter how high the system pressure may be. And since system pressure is balanced out on both sides of the diaphragm, then, regardless of system pressure, the force required of the diaphragm will remain the same for a given resistance and the work required of the heart will be proportional to the resistance to flow encountered and the pumping pressure needed to overcome that resistance. It will be independent of system pressure.

So now our circulating system has met its basic requirements. It is a closed system, free from contamination and loss of fluid; it is jam-proof, or as nearly so as is necessary for practical purposes; it is flexible; and it is as economical of power as possible, since the only energy required is that needed to circulate the fluid. It is unaffected by system pressure.

But what of system pressure? How is it generated and why is it necessary?

How, in a closed system without external reservoirs or externally applied forces, can we generate a pressure higher than that of the surrounding atmosphere, and not only generate it but change it as conditions vary? Go back again to the inner tube for an example.

It is literally a closed system, except for a valve which admits fluid from an outside source. But this valve can be closed at will, thus isolating the tube from external sources of fluid and power, making it a closed system. Now evacuate all the air from the tube and it will collapse completely, for there is an atmospheric pressure of 760 millimeters of mercury, absolute, acting on the outside of it, and no pressure acting on the inside. Fill it with water from an outside source, also at 760 mm pressure, and it will assume its normal doughnut shape. Close the valve and take a pressure reading of the fluid inside, and it will be 760 mm. But if water is forced into the tube at a pressure greater than that of the atmosphere, say 860 mm, then the walls of the tube will stretch. As the walls stretch, they will try to pull themselves back to their original shape, and the more the stretch, the greater the contracting tension in the walls. This contracting force, acting on the fluid, creates hydraulic pressure. The walls will continue to expand until the force they exert, the pressure they create, equals the pressure of the incoming water; then the flow will stop. Now close the valve, shutting off the outside source of pressure, and measure the pressure of the fluid in the tube. It will still be 860 mm abs., maintained by the force exerted by the tensed walls.

If a piece of pipe is substituted for the tube, what will happen? Assuming that the pipe walls are completely rigid and cannot stretch, what will happen if we fill it from an external source of fluid at a pressure of 860 mm? So long as the valve remains open, so long as an external force can act on the fluid, the pressure will remain at 860 mm; but if the valve is closed, cutting off the external source of pressure, and the pressure of the liquid in the pipe is checked, it will be the same as that of the atmosphere (technically, it could be claimed that it has no pressure whatever, but this is a fine point, not worth discussing here). The reason for this lack of extra pressure is apparent. In the inner tube, pressure was sustained by the tension in an elastic wall; in the pipe, there was no elasticity in the wall and therefore no tension exerted on the fluid. Ergo, no pressure. So it seems that system pressure is maintained solely by tension in the walls of the ducts and pump; that the ability to exert this pressure is a function of the elasticity of the duct walls; that completely rigid walls could maintain no system pressure; that, therefore, high system pressure is not due to "hardening" of the arteries. Rather it is due to very active, very contractile duct walls, which may get pretty tough from overwork.

There is one basic difference between the action of the duct walls in our system and the walls of the inner tube. In the inner tube we increased the pressure by injecting more water into the tube, thus stretching the walls. To decrease the pressure we would have had to let out some of the water. Although blood is generated in the human body and enters the circulatory system by osmosis or some other esoteric process to replace worn-out blood, we must assume that at any given moment the system contains a supply of fluid which cannot be readily augmented from outside sources. But system pressure must fluctuate suddenly, for reasons to be explained later. Since we cannot add or subtract fluid to change the tension in the duct walls, it is necessary to change their tension without stretching or shrinking them, without changing their dimensions. Here is where the wonderful self-energizing plastic does its best work. For it can *tend* to contract or relax without dimensional change, while the tension in a piece of rubber will vary only as it stretches or shrinks. Unlike rubber, the wall of our duct can dilate and still exert decreased tension; or it can contract while exerting increased tension, thus changing the force on the fluid in the ducts and so changing the pressure. The flexing of the cell walls, like the movement of the diaphragm, is a factor of our self-energizing plastic, but the signal for such action is conveyed by the nervous system, part of the human intelligence. It does not matter, however, how the signals are received; it concerns us here only that our plastic will respond to a given signal, and will produce a needed mechanical force when necessary. And we know what mechanical

force is necessary to create system pressure, how it is maintained within the scope of this project.

Why is it necessary?

A flexible tube can withstand high internal pressures, but it will collapse, as the tire did, when pressure inside drops. It is possible to drive a heavy car over a high-pressure fire hose without flattening it; it will still stay nearly round, and continue to pass an uninterrupted flow of water, even while the car rests on it. Many outside forces are exerted on the ducts in the circulatory system; sitting, standing, leaning may result in a tendency to squeeze off some duct — may tend to interrupt the flow of blood to a large area. To prevent this, system pressure must be high enough so that the external force cannot easily flatten the duct. Indeed, you physicians check blood pressure by exerting an external force great enough to flatten the ducts and cut off the flow of fluid. By measuring the force or pressure required, you tell what the pressure inside the duct is, for the two will be the same. So the first reason for system pressure is to resist external forces which would flatten the ducts.

There are more important reasons, however. Consider the normal blood pressure of 120 over 80 millimeters. This is the pressure in the outlet and inlet ducts, respectively, of our system. More correctly, it is the excess of pressure over that of the surrounding atmosphere. This pressure is for a normal heart pumping blood under normal conditions, and is taken during the working stroke of the diaphragm. It means that the pressure at the outlet to the pump is 40 millimeter higher than at the inlet; it also means that the pressure at the beginning of the resistance duct is 40 millimeters greater than at the end of it. The pressure created by the pump has been absorbed by the resistance to flow in the small duct. Stop the diaphragm momentarily (we hope the patient doesn't die), and the flow will cease, as will the resistance to flow. Then the pressure in the system will be equalized throughout, and will be the average of the high and low pressure, or 100 millimeters. Start the diaphragm again, and the pressure will build up in the outlet and drop in the inlet until it is back to 120 over 80. But without this system pressure, the high and low would be 20 and minus 20; then the pressure in the inlet line would actually be less than the atmospheric pressure acting on it. Add the external forces normally tending to squeeze the duct shut, and it would be more than probable that circulation would be interrupted. So system pressure must be great enough to resist squeezing forces *on the low pressure side.*

Now, assume that this 80 millimeters of pressure in the inlet duct is as low as we can go and still resist outside forces. And suppose that the resistance to flow were to increase, owing to clogging of the small duct — were to become, not 40, but rather 60 millimeters. If system pressure did not change, but remained at 100, the reading would be 130 over 70 — too low at the inlet duct to prevent collapse. But if system pressure were increased to 110 with the 60 millimeter difference, the reading would become 140 over 80, and the inlet duct could again withstand external forces. So the system pressure must vary to prevent collapse of the low-pressure or inlet ducts as the resistance to flow and the corresponding pump pressure vary.

What can cause the resistance to flow to change, and with it that important difference in pressure? For that difference in pressure is the important thing: the measure of the work that the heart does. System pressure may impose a severe strain on the walls of the pump and the ducts, and they may eventually blow out, with disastrous results; but it is that *pressure difference* that is critical—that makes the pump diaphragm strain until it gives out.

The faster the flow of fluid through a given duct, the greater the resistance to flow. Obviously, when the system calls for more blood in a hurry, and the heart starts to speed up, there will be an increase in resistance to flow, and a corresponding rise in the pump pressure, or pressure difference. And to keep that

pressure in the return ducts at a safe level, the duct walls must tense to raise the system pressure. Sudden exercise will raise first the pressure difference, then the system pressure. But it is not good to overload the diaphragm — to create too much pressure difference. Thus, when the system pressure rises, it also tends to drop the pressure difference back to normal. For the amount of fluid a duct can pass with a given resistance depends on its size. If increased flow through a duct of a given size means increased resistance, then we can bring the resistance back to normal by increasing the size of the duct. And the strong contractile walls of the large ducts will work to raise the system pressure at the same time that the walls of the small ducts are relaxing. Thus, the increased pressure will expand them, and they will carry more fluid. So the increase in system pressure, sparked by the increase in resistance to flow — by increased pressure difference — actually permits that pressure difference to return to normal, easing the load on the diaphragm. One more use of system pressure accounted for!

As we get older, our glands become less active, our metabolism becomes faulty, and the waste products from the tissues are not what they should be; they may be poisonous, or corrosive, or a lot of other things. Suppose they do not move out of the small ducts into the blood stream but stay behind to clog them; or that they damage the walls and scar tissue is formed? Then these small ducts get smaller, and their walls become less elastic, and less fluid can pass through them. Then the tissues, starved, cry out for blood. Resistance to flow becomes greater, and the pump pressure must rise. So the contractile walls go to work in earnest, raising the system pressure ever upward in a continuing attempt to dilate the small ducts so that fluid can pass through them without encountering excessive resistance, without needing excessive pump pressure, without straining the pump diaphragm. And by varying the contractile force of various ducts, the flow can be directed to the point where it is needed, by easing the path to that point; by enlarging that path and lowering the resistance in that line. It is not implausible to picture a complex console, receiving messages of need and then playing on the whole circulatory system to direct and proportion the flow of blood through the body. But the control, as we said, is another story. We have concerned ourselves here only with the conditions which must be met to provide a system capable of efficient functioning.

There are many factors involved in the flow of fluid which present problems which we have not discussed here. Capillarity augments the use of pressure to keep fluid flowing in extremely small ducts. Problems of transverse areas and wall areas, length of ducts, pressure waves generated by the pulsing pump, and a host of others present themselves for solution. And the way in which the human body works to overcome them is sometimes obscure. But these problems need not confuse the basic principles that exist in the circulatory system. The functions which have been outlined in this article are all necessary if the system is to work according to physical laws, and it cannot work contrary to those laws.

Nor are these functions peculiar to the human anatomy; they are encountered wherever fluids are pumped. And because they are common to all problems of hydraulics, we have tried to express them in common terms. Veins and arteries and capillaries are still ducts; sphygmomanometers are only pressure gages; systolic and diastolic pressures are only esoteric terms for outlet and inlet pump pressures. And no physiological complications, no nervous controls or reactions which the medical profession may know of (or discover) can change the principles outlined. These things must be.

This is a mechanical analysis, not a discussion of physiology. But from it certain generalizations can be drawn.

Blood pressure, high or low, is not a disease. If your skin itches, it may be diseased; scratching it to relieve the itch is not a disease, it is a mechanical action which seeks to overcome

a condition. Your blood pressure will alter, insofar as it is muscularly capable of doing so, to meet conditions of need in the body.

The differential pressure is the measure of the work your heart is doing, and an indication of the condition of the small ducts and capillaries, of the resistance they offer to the flow of blood through them. But it means that the heart is still capable of responding to a need, of maintaining the increased pressure required, overworked though it may be.

A high system pressure, while dangerous from the standpoint of blowouts, at least indicates that the system still can sense a need, and can respond to it.

When differential pressure is high and system pressure is low — then the circulatory system is failing to perform all of its functions — the contractile walls are either too inelastic to maintain pressure or the signals have failed. And when both system pressure and differential pressure are high, then the circulatory system is doing all that it physically can to overcome a condition over which it has no control. About the only solution here is to scrub out the capillaries one by one.

"Hardening" or inelasticity of the large ducts, or arteries, can only tend toward lower system pressure; clogging of the small ducts, or capillaries, must inevitably result in higher differential pressures.

So the fundamental problem of reducing high blood pressure, as it appears to the engineer, is to improve the metabolism and reduce infection so that the tissues of the body, the small ducts, and the capillaries will be free and elastic, and the arteries will take care of themselves. But this is the doctor's job, not ours.

Box 124

Driver Reaction Patterns

The way a driver of an automobile sees and reacts in traffic may determine the kind of accident he will have, according to a study of taxicab drivers in Washington, D.C. The report finds that drivers who were slow to size up a situation but who compensated by slamming on the brakes were more likely to be struck from behind than other drivers. The drivers most often struck from behind, however, usually had fewer accidents of other types than the other drivers did.

The findings are in a study on "Driver Reaction Pattern and Struck-from-Behind Accidents" by Paul Babarik. The project was carried out by the American Institutes for Research and was supported by the U.S. Public Health Services' Division of Accident Prevention.

Each of 127 cab drivers was tested for his reaction time by calculating how long it took him to press a switch in response to a light signal. Each also was asked the number and kind of accidents he had had in the previous five years. Of those with slow perception but fast movement times, 36 percent had been struck from behind more than once. This compared with only 10 percent of the drivers who had more normal reactions.

"A note of caution is called for," Mr. Babarik added: "These findings may apply only to taxicab drivers . . . who often stop for reasons that are unapparent to the following drivers, such as a fare's instruction to 'Stop right here' " or a prospective passenger waving from the curb.

STATE ACTIVITIES

1966-1967 SPECIAL COMMITTEES SPECIAL/LIAISON REPRESENTATIVES

Academy of Medicine of New Jersey

(1) Board of Trustees/Liaison Committee
(Liaison requested by Academy — 6/19/66)
Joseph P. Donnelly, M.D., *Chairman* Jersey Ctiy
Thomas C. DeCecio, M.D. Cliffside Park
Nicholas E. Marchione, M.D. Vineland
(2) Post-Graduate Medical Education Study Committee
(Representative requested by Academy — 11/15/64)
Sherman Garrison, M.D. Bridgeton

Air Pallution, Advisary Committee to (State) Commission on

(Liaison requested by State Health Department — 11/19/61)
Special Committee on Air Pollution

American Medical Assaciation— Education Research Foundation

(Liaison requested by AMA — 10/7/51)
Chairman, Medical Student Loan Fund Committee
Luke A. Mulligan, M.D. Leonia

Audit Review Cammittee (1965-1966 Audit)

(Appointed annually by Board to review previous year's audit)

Samuel J. Lloyd, M.D., *Chairman*	Trenton
Louis F. Albright, M.D.	Spring Lake
Frank J. Hughes, M.D.	Gloucester
Nicholas E. Marchione, M.D.	Vineland
Andrew C. Ruoff, M.D.	Pompton Plains
Consultants:	
Daniel F. Featherston, M.D. *Treasurer*	Asbury Park
Thomas C. DeCecio, M.D., *Chairman, Finance and Budget Committee*	Cliffside Park

Bicentennial History

(Committee appointed to expedite publication of history — 7/18/65)

Emanuel M. Satulsky, M.D., *Chairman*	Elizabeth
Samuel J. Lloyd, M.D.	Trenton
Fred B. Rogers, M.D., *Historian-Archivist*	Trenton
George B. Sharbaugh, M.D.	Trenton
Richard 1. Nevin, *Executive Director*	Trenton

Blood Bank Commission of New Jersey

(1) Formation of Commission authorized by 1953 House of Delegates
Authorized agent of MSNJ in approved Blood Bank Programs
(2) Appointment of two representatives requested by Commission — 4/5/54
Jerome G. Kaufman, M.D. Maplewood
John J. Torppey, M.D. Newark

Blue Cross-Blue Shield Plans of New Jersey, Permanent Committee on

(Appointment of committee requested by MSP — 4/16/60)

Frank J. Hughes, M.D., *Chairman Board of Trustees*	Gloucester
Joseph R. Jehl, M.D., *President*	Clifton
Richard 1. Nevin, *Executive Director*	Trenton
*John J. Bedrick, M.D.	Bayonne
*Nicholas A. Bertha, M.D.	Wharton

Equal representation from:
Medical Service Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association
*for 1966-67 only

Blue Cross Rates, Gavernar's Committee on

(Special committee appointed by Governor — 9/19/65)
John J. Bedrick, M.D. Bayonne

Board af Cantral, Department af Institutions and Agencies

(Appointed by Governor for 8-year term)
Frank J. Hughes, M.D., June 1971 Camden

Baard of Nursing, New Jersey State

(Liaison requested by Board of Nursing — 11/21/65)
Jesse McCall, M.D. Newton

Bureau af Investigation, Department of Law and Public Safety

(Cooperating committee requested by Department of Law and Public Safety — 9/61)
Board of Trustees

Cardiac Advisory Panel to Director af Motar Vehicles

(Panel requested by Special Commission on Traffic Safety — 9/17/61 . . . appointed by the Director of Motor Vehicles)

Jerome G. Kaufman, M.D., *Chairman*	Maplewood
Louis F. Albright, M.D.	Spring Lake
Jesse McCall, M.D.	Newton
James G. Kehler, M.D.	Woodbury

Cardiapulmanary Resuscitation, Special Committee to Evalve Statement on

(Committee established at suggestion of Commissioner of Health — 3/21/65)

Philip J. Kunderman, M.D.	New Brunswick
William E. Philip, M.D.	Morristown
George N. J. Sommer, Jr., M.D.	Trenton

Chamber af Cammerce Legislative Conferences

(Invited by Chamber — 1/15/61)
Richard 1. Nevin, *Executive Director* Trenton

Chranic Sick, State Advisary Council

(Commissioner of Health requested MSNJ submit names to Governor — 10/16/60 . . . appointed by Governor for 3-year term)
William D. Kimler, M.D.
December 1967 Haddon Heights

Civil Defense Organization, Liaisan With State

(Liaison established by MSNJ — 5/22/55)
Jack R. Karel, M.D., *Chairman, Disaster Medical Care Committee* Hillside

Constitution and Bylaws, Study Committee on Revision of

(Established at request of 1966 House of Delegates)

Louis F. Albright, M.D., *Chairman* (Committee) — Spring Lake
Lorrimer B. Armstrong, M.D. — Westfield
George E. Barbour, M.D. (Board) — Somerville
Joseph M. Gannon, M.D. (Committee) — Plainfield
Samuel J. Lloyd, M.D. (Board) — Trenton
Carl N. Ware, M.D. — Ocean City

Crippled Children Commission, State

(Appointed by Governor for a 5-year term)

Frederick G. Dilger, M.D., May 1971 — Hackensack

Diabetes Detection Drive

(Liaison representative for annual drive — cosponsored by State Department of Health, New Jersey Diabetes Association, and MSNJ — appointed at request of Commissioner of Health — 5/16/54)

John J. Torppey, M.D. — Newark

Disputed Claims, Advisory Committee to Review MSP and HSP

(Established at request of MSP — 8/21/60) — Quorum: 4 members

1st District—
F. Clyde Bowers, M.D., *Chairman* — Mendham
Ralph M. L. Buchanan, M.D. — Phillipsburg
2nd District—
John J. Bedrick, M.D. — Bayonne
Robert A. Cosgrove, M.D. — Jersey City
3rd District—
John S. VanMater, M.D. — New Brunswick
John A. Kinczel, M.D. — Trenton
4th District—
John C. Clark, M.D. — Asbury Park
Reuben L. Sharp, M.D. — Camden
5th District—
Louis K. Collins, M.D. — Glassboro
Nicholas E. Marchione, M.D. — Vineland

Education, State Department of

(Liaison requested by the Assistant Commissioner of Education — 9/21/58)

Dorothy K. Klughaupt, M.D., *Chairman, Special Committee on Child Health* — Passaic

Emotionally Disturbed Child, Advisory Council to Department of Education

(Appointed by Commissioner of Education — 9/16/63)

Robert E. Jennings, M.D. November 1966 — South Orange

Epilepsy, Advisory Panel to State Director of Motor Vehicles

(Established at request of Director of Motor Vehicles — 7/29/66)

Francis A. Wood, M.D. — Newark

Executive Committee

(Provided in the Bylaws, Chapter IV, Section 5 (b))

Joseph R. Jehl, M.D., *President* — Clifton
Louis K. Collins, M.D., *President-Elect* — Glassboro
John F. Kustrup, M.D., *First Vice-President* — Trenton
Nicholas A. Bertha, M.D. *Second Vice-President* — Wharton
Frank J. Hughes, M.D., *Chairman Board of Trustees* — Gloucester

Fluoridation, Joint Committee on

(Established at request of the State Department of Health)

Edwin H. Albano, M.D. — East Orange
John P. Coughlin, M.D. — Jersey City
Equal representation from:
State Department of Health
New Jersey State Dental Society

Headquarters, Investigation of Future

(Committee established by Board — 6/19/66)

Nicholas A. Bertha, M.D., *Chairman* — Wharton
Samuel J. Lloyd, M.D. — Trenton
Emanuel M. Satulsky, M.D. — Elizabeth

Health Facilities Planning Council

(MSNJ invited to nominate 3 members for the Board of Trustees — 2/16/64 . . . appointed by Council to serve for a 3-year term)

Louis F. Albright, M.D. (1967) — Spring Lake
John F. Kustrup, M.D. (1969) — Trenton
Jesse McCall, M.D. (1968) — Newton

Health Insurance Conference

(Committee established at request of Health Insurance Council — 3/24/57)

Daniel F. Featherston, M.D., *Chairman* — Asbury Park
Marcus H. Greifinger, M.D. — Newark
Jerome G. Kaufman, M.D. — Maplewood
Joseph R. Jehl, M.D., *President* — Clifton
Louis K. Collins, M.D., *President-Elect* — Glassboro
John F. Kustrup, M.D., *First Vice-President* — Trenton
Nicholas A. Bertha, M.D., *Second Vice-President* — Wharton
Richard I. Nevin, *Executive Director* — Trenton

Health Careers Service, Resource Persons to New Jersey

(Liaison established at request of Health Careers Service — 7/19/64)

Presidents of Component Societies

Health, State Department of

(Liaison requested by Commissioner of Health—6/6/54)

John P. Coughlin, M.D., *Chairman Council on Public Health* — Jersey City

Heart Disease, Cancer, and Stroke

(1) New Jersey Joint Committee for Implementation of P.L. 89-239
(Established at request of Commissioner of Health —11/21/65)
John J. Bedrick, M.D. — Bayonne
Louis F. Albright, M.D. — Spring Lake
Louis K. Collins, M.D. — Glassboro
Joseph R. Jehl, M.D. — Clifton
Jerome G. Kaufman, M.D. — Maplewood
Richard I. Nevin, *Executive Director* — Trenton

(2) University City Science Center, Philadelphia
(Established at invitation of University City Science Center — 12/65)
Louis K. Collins, M.D. — Glassboro

Historian-Archivist

(Created at the suggestion of the Executive Director — 1/13/57)

Fred B. Rogers, M.D. — Trenton

Hospital Advisory Council, State Department of Institutions and Agencies

(Appointed by the Board of Control for a 4-year term)

C. Byron Blaisdell, M.D., December 1967 — Asbury Park
Luke A. Mulligan, M.D., December 1969 — Leonia

Hospital Service Plan Board of Trustees
(Provided in HSP Bylaws)
Joseph R. Jehl, M.D., *President* ..... Clifton

House Maintenance, Staff Policies, and Personnel Relations
(Special committee created by Board of Trustees — 9/21/58)
Joseph R. Jehl, M.D., *President, Chairman* Clifton
Louis K. Collins, M.D., *President-Elect* .... Glassboro
Marcus H. Greifinger, M.D., *Secretary* .. Newark
Daniel F. Featherston, M.D., *Treasurer* .. Asbury Park
Frank J. Hughes, M.D., *Chairman Board of Trustees* ..... Gloucester
Thomas C. DeCecio, M.D., *Chairman Committee on Finance and Budget* Cliffside Park
L. Samuel Sica, M.D., *Chairman, Former House Committee* ..... Trenton
Richard I. Nevin, *Executive Director* Trenton

Industrial Safety Board, New Jersey
(Nominations — 3 names — for appointment of 1* by Governor — requested 11/21/65)
Rufus W. Miller, M.D. ..... Trenton
Joseph A. Lepree, M.D. ..... Elizabeth
Delma W. Caldwell, M.D. ..... Linden
*designation not yet made

Institutions and Agencies, State Department of
(Liaison established 7/16/61)
Frank J. Hughes, M.D. ..... Gloucester

Intra-Hospital Infections, Joint Committee on
(Established at request of Commissioner of Health — 4/8/62)
Edwin H. Albano, M.D., *Chairman* East Orange
Lawrence Gilbert, M.D. ..... Newark
Thomas K. Rathmell, M.D. ..... Trenton
Eugene H. Kain, M.D. ..... Camden
Equal representation from:
State Department of Health
New Jersey Hospital Association
New Jersey State Nurses' Association

Judiciary and Bar, Conference Committee on Inter-Relations with the
(Established at invitation of Supreme Court—11/17/63)
John P. Coughlin, M.D. ..... Jersey City
E. Vernon Davis, M.D. ..... Mount Holly
Joseph P. Donnelly, M.D. ..... Jersey City
Daniel F. Featherston, M.D. ..... Asbury Park
Joseph M. Gannon, M.D. ..... Plainfield
Marcus H. Greifinger, M.D. ..... Newark
Jerome G. Kaufman, M.D. ..... Maplewood
Samuel J. Lloyd, M.D. ..... Trenton
Nicholas E. Marchione, M.D. ..... Vineland
Jesse McCall, M.D. ..... Newton
Richard I. Nevin, *Executive Director* ..... Trenton
Equal representation from:
Supreme Court Committee on Relations with the Medical Profession

Lay Health Organizations and Paramedical Groups
(Established by MSNJ — 6/17/57 . . . Assignment of official intermediaries from MSNJ to lay health organizations and/or paramedical groups does not imply endorsement of the organization/group or its program)
Members of the Council on Public Health, as assigned by the chairman

Legislation
(1) Federal Keymen
(Mechanism established by MSNJ — 4/4/54 . . . to serve as official intermediaries beteen MSNJ and the Federal Legislators)
15 Congressional District Keymen
1 Senatorial Keyman
(2) State Keymen
(Mechanism established by MSNJ — 7/13/52)
Keymen in 14 Senatorial Districts/21 Component Societies

Medical Assistants, New Jersey Association of
(Liaison requested by Association — 9/15/63)
Vincent H. Gillson, M.D. ..... Westwood

Medical-Hospital-Nursing Conference (Tri-Partite)
(Liaison established by MSNJ — 1/13/57)
Joseph R. Jehl, M.D., *President* Clifton
Louis K. Collins, M.D., *President-Elect* Glassboro
John J. Bedrick, M.D., *Immediate Past-President* ..... Bayonne
Richard I. Nevin, *Executive Director* Trenton
Equal representation from:
New Jersey Hospital Association
New Jersey State Nurses' Association

Medical Liaison Committees
(High-level conference groups for discussion and consideration of items of mutual interest)
(1) Medical-Dental
(Liaison requested by the Dental Society — 6/10/51)
(2) Medical-Hospital
(Liaison established by MSNJ — 10/25/53)
(3) Medical-Legal
(Liaison established by MSNJ — 10/25/53)
(4) Medical-Nursing
(Liaison established by MSNJ — 4/4/54)
(5) Medical-Osteopathic
(Liaison requested by Osteopathic Association — 9/17/61)
(6) Medical-Pharmaceutical
(Liaison established by MSNJ — 7/26/53)
Joseph R. Jehl, M.D., *President* ..... Clifton
Louis K. Collins, M.D., *President-Elect* Glassboro
John J. Bedrick, M.D., *Immediate Past-President* ..... Bayonne
Richard I. Nevin, *Executive Director* Trenton
(Where number of representatives from other organization is larger than number of MSNJ representatives, the latter will be increased from the Presidential Officers to equal the former.)

Medical Schools in New Jersey, Committee on Development of
(Established by Board — 9/20/64)
Joseph R. Jehl, M.D., *Chairman* ..... Clifton
Louis K. Collins, M.D. ..... Glassboro
Joseph P. Donnelly, M.D. ..... Jersey City
Jerome G. Kaufman, M.D. Maplewood
Fred A. Mettler, M.D. Blairstown

Medical-Surgical Plan Board of Trustees
(Provided in MSP Bylaws)
Joseph R. Jehl, M.D., *President* ..... Clifton

Medicare Law (P.L. 89-97)
(Assigned by the Board — 10/17/65 as indicated below)
(1) Overall responsibility to study and provide recommendations concerning the Medicare Program
Council on Medical Services
Consultants to the Council on Medical Services:
Joseph R. Jehl, M.D., *President* ..... Clifton

Louis K. Collins, M.D., *President-Elect* ..... Glassboro
Jesse McCall, M.D., *Chairman Council on Legislation* ..... Newton
John P. Coughlin, M.D., *Chairman Council on Public Health* ..... Jersey City
Matthew E. Boylan, M.D., *Chairman Committee on the Chronically Ill and the Aging* ..... Jersey City
David Eckstein, M.D., *Chairman, Former Joint Council to Improve the Health Care of the Aged* ..... Trenton
Frank J. Hughes, M.D., *Member New Jersey Board of Control* ..... Gloucester

(2) Liaison representative to State Department of Health
(Established by MSNJ — 1/16/66)
David Eckstein, M.D. ..... Trenton

(3) Liaison representative to State Department of Institutions & Agencies
(Established by MSNJ — 1/16/66)
Francis J. Benz, M.D. ..... Chatham

(4) Home-Hospital-Nursing Care
(Liaison established by MSNJ — 3/20/66)
Matthew E. Boylan, M.D. ..... Jersey City

Membership Directory

(Special Committee established by Board — 11/19/61)
Marcus H. Greifinger, M.D., *Chairman* ..... Newark
John J. Bedrick, M.D. ..... Bayonne
Nicholas A. Bertha, M.D. ..... Wharton
George B. Sharbaugh, M.D. ..... Trenton
Louis S. Wegryn, M.D. ..... Elizabeth
Richard I. Nevin, *Executive Director* ..... Trenton
Robert H. Lambert, *Office Manager* ..... Trenton

Motor Vehicles, State Division of

(Liaison established at the request of the Division — 4/16/61)
William L. Sprout, M.D. ..... Salem

Neurological Diseases, Advisory Council to New Jersey Consultation Service for Convulsive Disorders

(Liaison established — 7/19/64)
Robert S. Garber, M.D. ..... Belle Mead

New Jersey College of Medicine and Dentistry, Student AMA

(Liaison requested by New Jersey Chapter—1/26/60)
Joseph P. Donnelly, M.D. ..... Jersey City

Nursing Education and Recruitment, Permanent Committee on

(Established by direction of 1963 House of Delegates)
Jesse McCall, M.D., *Chairman* ..... Newton
George E. Barbour, M.D. ..... Somerville
William P. Mulford, M.D. ..... Beverly
Lewis E. Savel, M.D. ..... South Orange
Richard I. Nevin, *Executive Director* ..... Trenton
Equal representation from:
New Jersey League for Nurses
New Jersey Hospital Association
New Jersey State Nurses' Association
Administrators of Nursing Schools
Advisors (2) from State Department of Education

Nutrition Council, New Jersey

(Liaison established by MSNJ — 12/19/54)
S. William Kalb, M.D. ..... Newark

ODMC (Office of Dependent's Medical Care)

(1) Fiscal Agent
(Designated, upon request of MSP — 7/21/63)
Medical-Surgical Plan of New Jersey

(2) Special Committee on
(Established by MSNJ — 9/9/56)
Nicholas A. Bertha, M.D., *Chairman* .. Wharton
George E. Barbour, M.D. ..... Somerville
Thomas C. DeCecio, M.D. ..... Cliffside Park
L. Samuel Sica, M.D. ..... Trenton

Osteopathic Question, Special Committee on

(Requested by AMA — 11/19/62 . . . Reactivated by Board — 7/18/65)
Emanuel M. Satulsky, M.D., *Chairman* ..... Elizabeth
Louis K. Collins, M.D. ..... Glassboro
John J. Bedrick, M.D. ..... Bayonne

Parents and Teachers, New Jersey Congress of

(Liaison requested by MSNJ's Committee on Child Health — 12/20/64)
Joseph R. Jehl, M.D. ..... Clifton

Pension Plan, Special Committee on

(Established by Board — 5/22/55 . . . Duties outlined in Article III of Pension Plan Agreement)
Thomas C. DeCecio, M.D., *Chairman, Committee on Finance and Budget* ..... Cliffside Park
Joseph R. Jehl, M.D., *Chairman, Special Committee on House Maintenance, Staff Policies, and Personnel Relations* ..... Clifton
Daniel F. Featherston, M.D., *Treasurer* .. Asbury Park

Project Hope, Special Committee on

(Special Committee created by Board, to implement Resolution #3 adopted by the 1966 House of Delegates — 5/18/66)
Thomas C. DeCecio, M.D., *Chairman* .. Cliffside Park
Nicholas A. Bertha, M.D. ..... Wharton
Andrew C. Ruoff, III, M.D. ..... Pompton Plains

Public Health Association, New Jersey

(1) Membership authorized by Board — 11/15/59
Joseph R. Jehl, M.D., *Delegate* ..... Clifton
Richard I. Nevin, *Alternate* ..... Trenton

(2) Animal (Medical) Research
(Liaison representative requested by Association — 4/17/66)
Edwin H. Albano, M.D. ..... East Orange

(3) Medical Care Committee
(Association requested physician to serve as chairman of its Medical Care Committee — 2/24/65)
John J. Bedrick, M.D. ..... Bayonne

Public Health Council, State Department of Health

(Nominations for appointment by Governor . . . for a two-year term requested — 9/20/64)
Henry L. Drezner, M.D. ..... Trenton

Publication Committee, Trustee Members to Augment

(Appointment by the Board — 9/16/62)
Daniel F. Featherston, M.D. ..... Asbury Park
Frank J. Hughes, M.D. ..... Gloucester
Joseph R. Jehl, M.D. ..... Clifton
Samuel J. Lloyd, M.D. ..... Trenton

Quackery, Committee on

(Established at the request of the AMA — 11/15/64)
Thomas C. DeCecio, M.D., *Chairman* .. Cliffside Park
Henry J. Mineur, M.D. ..... Cranford
Charles B. Norton, M.D. ..... Woodstown

Radiation Protection Commission, Consultant to New Jersey
(Nomination for appointment to Commission requested — 7/18/65)

Bernard M. Schur, M.D. — Trenton

Rehabilitation Commission, New Jersey State
(Liaison requested by MSNJ Committee on Rehabilitation — 5/65)

Carl A. Maxwell, M.D. — Phillipsburg

Safety Council, New Jersey State
(Provided in Council Bylaws)

Joseph R. Jehl, M.D., *President* — Clifton
William L. Sprout, M.D., *President's representative* — Salem

Selective Service System, New Jersey Chairman of Advisory Committee to
(Nomination for appointment by National Advisory Committee requested by committee — 11/19/61)
Jesse McCall, M.D. — Newton

Special Committee Structure, Study of
(Established by Board at direction of 1964 House of Delegates)

John J. Bedrick, M.D., *Chairman* — Bayonne
John P. Coughlin, M.D. — Jersey City
Joseph R. Jehl, M.D. — Clifton
Nicholas E. Marchione, M.D. — Vineland
Richard I. Nevin, *Executive Director* — Trenton

Tuberculosis Council, New Jersey State
(Appointment of representative to council requested by Commissioner of Health — 2/19/61)

John P. Coughlin, M.D. — Jersey City

Welfare Council, New Jersey
(Representative to plan meetings for annual conference on social welfare requested by council — 5/13/66)
John J. Bedrick, M.D. — Bayonne

Widows and Orphans of Medical Men of New Jersey, Society for Relief of
(Liaison requested by Society — 5/17/59)
Joseph R. Jehl, M.D. — Clifton

OBITUARIES

Dr. Eugene Bekampis

A freak accident on August 27, 1966 took the life of Dr. Eugene Bekampis, a prominent Camden County obstetrician. The doctor and his wife were in an 18-foot motor boat when they were hurled out of the vessel and into Delaware Bay by another boat which crashed over the bow. The propeller of the ramming boat cut into Dr. Bekampis, causing fatal head and neck injuries. Dr. Bekampis, born in 1915, received his M.D. degree at Hahnemann in 1941. He did graduate work in obstetrics and served as senior assistant obstetrician at the West Jersey Hospital in Camden. He had his private practice at Cherry Hill. He was active in the affairs of the Camden County Medical Society.

Dr. Peter G. Berkhout

An automobile accident in Colorado on July 19, 1966 took the life of Dr. Peter G. Berkhout, one of Paterson's best known physicians. He was 71 years old at the time of his death, but still made house calls and engaged in a busy and active practice. He received his M.D. at the University of Chicago in 1932 and interned in Grand Rapids, coming to New Jersey a few years later. Dr. Berkhout was a prominent figure in the Christian Reformed denomination, and was often a delegate to that Church's national Synod. He was a trustee of Calvin College, a director of the Eastern Christian School Association, health officer for the Boro of Prospect Park (New Jersey), and president of the Paterson Philharmonic Society. He was a first class amateur astronomist and the 1964 laureate of the Passaic County Medical Society's medal for outstanding service to the public.

Dr. William Koslow

A motor cycle accident on August 20, 1966, took the life of William W. Koslow, M.D., the 36-year old director of radiology at the Jersey City Medical Center. Dr. Koslow received his M.D. degree at the University of Basel, Switzerland, in 1956. After interning in Queens, he went to New Haven for a three-year residency in radiology at the Yale University Medical Center. He then came to the Jersey City Medical Center, soon becoming director of the department. He was a diplomate in radiology and active with the American College of Radiologists.

Dr. Benjamin F. Lee

At the untimely age of 54, Benjamin Francis Lee died on August 13, 1966. A 1937 graduate of the medical school of the University of Pennsylvania, he interned at Cooper Hospital until 1938 and then took a surgical residency there. Completing this, he was commissioned in the medical corps of the U.S. Navy. On being mustered out in 1947, he entered private practice in the city of Camden. Dr. Lee was a board diplomate in surgery, chief of surgery at the Zurbrugg Memorial Hospital in Riverside, senior consultant at the Ancora State Hospital, and FACS, and an instructor at the Jefferson Medical College. He was active in civic and athletic activities in South Jersey and president of the Haddonfield Skating Club. Dr. Lee was a senior attending surgeon at the Cooper Hospital.

Dr. Augustin M. Schultz

At the grand age of 82, Dr. Augustin M. Schultz died on July 1, 1966. Born in Paterson, he served the people of that area for over half a century. He was cited by Fordham University last year for his 50 years of practice, and he was also the laureate of the Golden Merit Award of The Medical Society of New Jersey. He earned his M.D. at Fordham in 1915. Dr. Schultz was a pioneer in proctology, and was, indeed, one of the founders of the N.J. Proctologic Society. In 1958 he received the VFW's "Outstanding Citizen" award for Passaic County. Dr. Schultz was also active in rehabilitation work and served our state's Rehabilitation Commission in many posts over the past three decades.

Dr. Benjamin Silverstein

One of northern New Jersey's well-known, senior general practitioners died on July 21, 1966. Born in Russia in 1889, he was brought to Newark in childhood. In 1910, at the early age of 21, he received his M.D. degree at Bellevue. He practiced in Newark for over half a century, except for his service as a captain in the Army's Medical Corps in 1917-1918. Dr. Silverstein was proud to be known as a family doctor, serving both the Newark Presbyterian Hospital and the Newark Beth Israel Hospital in that capacity. In 1960 he was awarded the Society's Golden Merit Award for 50 years of service.

Dr. Max Singer

Dr. Max Singer of Irvington, one of Essex County's better known surgeons, died on June 24, 1966. Born in New York City in 1896, he moved to Newark as a child. In 1919 he received his M.D. at Bellevue. He became identified with the old Newark Memorial Hospital (now the Clara Maas) and with the Beth Israel. At the latter institution he went through all the grades, starting as a clinical assistant in surgery and retiring in 1961 as chief of surgery. Dr. Singer belonged to A.O.A., the honorary medical fraternity, and was a Fellow of the American College of Surgeons.

Dr. George W. Surgent

As he always wanted to, Dr. George W. Surgent died with his boots on. He was stricken with a fatal coronary attack while doing an autopsy on June 23, 1966. Dr. Surgent was 65 years old at the time of his death. He had received his M.D. degree at the University of Virginia in 1927. Dr. Surgent had two major fields of interest: phthisiology and pathology. In the former capacity he was active in the Blue Ridge Sanitorium. He had service since 1940 in the Passaic County Medical Examiner's Office. He also won local acclaim as an outstanding golf player.

Dr. William L. Vroom

Dr. William L. Vroom, possibly one of the senior physicians in the United States, died on October 1, 1966, having passed the one hundred mark. Dr. Vroom was born in Hoboken and received his medical training at New York University Medical School, getting his M.D. degree in 1888. He moved back to New Jersey shortly thereafter, and for the next three-quarters of a century served the town of Ridgewod and the county of Bergen in a wide variety of medical activities. See editorial comment on Dr. Vroom (page 449).

ANNOUNCEMENTS

Iron Poisoning Antidote

The U.S. Public Health Service announces that Deferoxamine gives promise as a valuable antidote for acute iron poisoning. Children who swallow tablets having iron content seem to be helped more quickly by Deferoxamine than by any other antidote. However, the drug is not always available. If you need it in an emergency, telephone the National Clearinghouse for Poison Control Centers at 800 North Quincy Street, Arlington, Virginia 22203 (Jackson 521-5600, ext. 6461). They will give you information as to where the nearest supply of Deferoxamine is available.

Graduate Study Cruise

The Albany Medical College has some vacancies on a 17-day cruise, starting January 6, 1967, calling at a variety of unusual Carribean ports. The faculty of the medical school will present a comprehensive shipboard program covering all specialties and general practice. Twenty-four hours of AAGP credit will be given to members of that Academy. For further information in this cruise, write to the Department of Postgraduate Medicine at the Albany Medical College, Albany, New York 12208.

The Challenge of Geriatrics

Saturday morning, October 22, when you can attend, is the time set for a colloquium on the problem of coping with the aged. Principal speaker, Dr. L. Cosin, is director of geriatrics at the United Hospital in Oxford, England. The speaker has been, quite literally, all over the world, both in studying geriatric programs and in explaining them. This extraordinary presentation will begin at 10:00 a.m. at the Kessler Institute on Pleasant Valley Way, West Orange. It is under the joint sponsorship of the Institute and of the New Jersey Academy of Medicine.

Learn While You Earn—In Las Vegas

Because of its many cultural and scientific attractions, Las Vegas, Nevada, has been selected for the next AMA Clinical Convention. This opens on November 27 (which is the Sunday *after* Thanksgiving Day) and runs for three days. This is a veritable postgraduate course for the busy practitioner. Indeed, the doctor who attends conscientiously will not only accumulate a packet of clinically useful information, but will also be kept away from the expensive, counter-attractions in the Nevada city, which get in the way of scientific study. For more details, write to the AMA's "Clinical Convention Manager" at 535 North Dearborn Street, Chicago 60610.

Seminar on Psychotropic Drugs

A practical colloquium on the new psychotropic drugs is scheduled for the following Wednesday mornings: October 26, November 9, November 23, and December 14. These will be at the State Hospital, Marlboro, New Jersey (near Red Bank). The essayists—Dr. Heinz Lehmann of Quebec and Dr. Nathan Kline of Orangeburg, New York—are distinguished researchers in this field. The meetings run from 9:30 a.m. to 12:00 noon. If you want directions for getting to Marlboro, write to Dr. Michael Simon, State Hospital, Marlboro, New Jersey 07746.

Essay Contest For Medical Students

In the last 15 years, medical students have won over $14,000 in awards from the American College of Chest Physicians. This year's essay contest offers cash prizes to undergraduate medical students for essays on any phase of diagnosis or treatment of disorders of the lungs, heart, or mediastinum. For details, write to Mr. Murray Kornfeld, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

BOOK REVIEWS

The Heart. Arthur Selzer, M.D. Berkeley, 1966, University of California. Pp. 301 ($5.95)

This is the first in a series of books called "Perspectives in Medicine." We are told that "this new series of books is intended for serious readers who wish to learn more about current medicine, but who cannot and should not be expected to read textbooks or scientific journals intended for physicians and medical students." It is doubtful whether this first book fulfills this quoted purpose.

Selzer is a prominent cardiologist whose medical writings are of excellent quality. But this book is not. For instance, page 104 is one long unbroken paragraph which makes for difficult reading. The illustrations vary markedly in quality. In one too-small picture, only the valves on the right side of the heart are shown with a statement that ones on the left are similar. This is confusing. Most of the illustrations are "explained in text." This makes understanding even more troublesome.

It is hard for me to judge whether an intelligent layman with no medical background would be able to follow the material here presented. Although in many areas there has been an excellent job of translating medical terms into simple language, in others it is more confusing than explanatory. There is, however, an excellent glossary at the end of the book, as well as a good index to help the reader.

Though the author is an outstanding cardiologist, this book lacks a certain ease of reading and clarity which would make it attractive to the "intelligent nonmedical reader."

ARTHUR BERNSTEIN, M.D.

Caring For The Aged. Bertram B. Moss, M.D. and Fraser Kent. New York, 1966, Doubleday and Company. Pp. 372. ($4.95)

A man retiring today at age 65 has a life expectancy of 15 years. There are now some 20 million Americans in the over-65 category, and the net count is increasing at the rate of 800 a day. Obviously this burgeoning segment of American humanity can't all be consigned to the scrap heap. In this wise and witty book, Dr. Moss and Mr. Kent review the commoner diseases of the aged, discuss nursing homes, make comments about frauds and quacks, and close with a helpful chapter about anticipating death and the handling of bereavement.

The authors give a good deal of space to the medical and surgical problems of the aged. But they say that the aged are too heterogenous a group to justify a separate specialty of geriatrics. They point out, however, that today's physicians are the first generation of doctors with the opportunity of studying and caring for large numbers of the aged. They discussed the concept of retirement into, rather than retirement away from, activity suggesting that the shift from a work-oriented to a leisure-oriented society is helpful in meeting this need. The book includes a sensible chapter on the economics of being old. (Their figures suggest that the median elderly couple has a gross income of only $2,825, whereas the most modest survival figure is about $3,000 a year.) The authors thoughtfully develop the popular idea (not necessarily the authors' idea) that the responsibility for the aged sick should be more often borne by the Government and less frequently by the family. The book is chock full of practical pointers on housing for the aged, tax problems, finding a good doctor, and even the touching matter of late blooming romances.

ULYSSES S. FRANK, M.D.

Psychotherapy and the Behavior Sciences. L. R. Wolberg, M.D. New York, 1966, Grune and Stratton. Pp. 196. ($6.75)

Within a compass of less than 200 pages, Wolberg shows how an individual's social and psychological transactions must be associated with his physiologic mechanisms and anatomic limitations. While emotional and psychological motivation obviously play a role in personality development — and in therapy — these motivational forces cannot be disembodied. From enzyme reactions to spiritual promptings, man exhibits a beautifully integrated mechanism subject to the laws of nature.

The author takes us from the single cell, through the anatomic substrates and physiologic and biochemical operations of the nervous system, through genetic factors, and into the area of cultural components. Here he includes anthropologic and sociologic forces. Wolberg discusses cybernetic, group dynamics, information theories, and religion. He suggests that psychotherapy must be influenced by all these methodologies. This vividly written, thought-provoking volume reminds us that anyone without medical training should not try to tamper with this complex, organically and chemically rooted mechanism. And one *with* medical training should approach it with humbleness.

HERBERT BOEHM, M.D.

Handbook of Cardiology For Nurses. 5th Edition. Walter Modell, M.D.; Doris R. Schwartz, R.N.; Louise S. Hazeltine, R.N.; Frederick T. Kirkham, Jr., M.D. New York, 1966, Springer. Pp. 323. (Illustrated) ($4.75)

Modern nursing care insists on a practical knowledge of many of the newer electronic devices used on the cardiac care stations. Very frequently it is the nurse who gets to the patient first while he is having his acute episode of fibrillation, or heartblock, or angina. It is now very practical in most hospitals to have the staff trained in monitoring of the defibrillator, ECG, and the ECG oscillograph, until the medical staff can arrive to take over.

Since its first edition in 1952, this handbook has served such a positive purpose, giving its reader a handy concise guide on the care of the cardiac patient. This fifth edition has included new chapters on resuscitation and special equipment; diet therapy; the coronary care unit; and the addition of new illustrations and useful forms. End of chapter references have been updated; practical case examples have been included.

The authors have composed a guide of considerable value to those nurses concerned with cardiac nursing care. This book would be useful at every I.C.U. station, in addition to the nurses' own library.

HARRY M. POPPICK, M.D.

Psychoneurosis and Schizophrenia. Edited by G. L. Usdin, M.D. Philadelphia, 1966, Lippincott. Pp. 192. (Price not stated)

A year ago, the Touro Infirmary in New Orleans staged a seminar on two major problems in psychiatry today: schizophrenia and psychoneurosis. Dr. Usdin brought in speakers from the four corners of the nation, and this book is a report of that colloquium. The formal papers are here reprinted, as well as the give and take of the unstructured panel discussion. As might be expected when fourteen distinguished psychiatrists get into one room, there is some confusion as to which prescription to follow. Thus, one speaker urges the therapist to take a more active role in schizophrenia, while another warns against the development of an intense transference. One speaker sees the psychiatrist as a mere "catalyst" in the therapeutic process, while another urges an aggressive effort to analyze the "psychosis-vulnerable ego." We are cautioned against "mere giving of insight" but also urged to get down to the point where we can show the patient how human contact can be gratifying.

On the "psychoneurosis" side of the picture, there was lively discussion of the constitutional factors, of the role of early life experience, of treatment aimed at relieving anxiety, and of treatment designed to uproot the basic conflict. Much of this part of the meeting was devoted to the role of the tranquilizing drugs with an implied conclusion that the phenothiazines, at least, were extremely useful in controlling anxiety. Overall, one was left with a feeling that we needed a more versatile therapeutic attitude and that a doctrinaire or dogmatic approach was unjustified and ineffective.

Abraham Lyff, M.D.

Current Diagnosis. Edited by H. F. Conn, M.D., R. J. Clohecy, M.D., and Rex B. Conn, Jr., M.D. Philadelphia, 1966, Saunders. Pp. 844, Illustrated. ($19.00)

With miracle drugs and modern surgical procedures, the emphasis in our profession has been increasingly on treatment. This has, unfortunately, led to a neglect of diagnostic precision. One way of counterbalancing this neglect is to consult this book. Here is a book to which you can turn when you suspect that a person may have a certain disease, and find instructions that are both concise and precise on whatever steps you need, to confirm your clinical impression. Useful old methods are remembered and recommended, and recently described ones are also listed.

The book is divided into several large sections, such as the infectious diseases, diseases of the ear, diseases of the blood-forming organs, disorders of metabolism, and so on. Each section is so divided into chapters and each chapter is written by an expert. The emphasis throughout is on usability and practicality.

Since no one can think of everything and since computers are not generally available, this book will bring to the clinician a comprehensive and up-to-date reference work which will sharpen his skills in this difficult art.

Victor Huberman, M.D.

Heritable Disorders of Connective Tissue. Victor A. McKusick, M.D. St. Louis, 1966, Mosby. Ed. 3. Pp. 499 with 192 illustrations. ($18.50)

Connective tissue not only connects various organs and parenchymatous tissues; it also, in a sense, connects the several specialties of medicine. The Marfan syndrome connects the cardiologist with the ophthalmologist. The Hurler syndrome is of interest to the orthopedist and the otologist. Ehlers-Danlos means something to the dermatologist as well as the chest physician.

The third edition of this standard work updates its material to the spring of 1966. It covers such well-known syndromes as alkaptonuria, Ehlers-Danlos, osteogenesis imperfecta and, of course, the Marfan syndrome. It also reviews the lesser known muco-polysaccaridoses pleonosteosis, fibrodysplasia ossificans, and homocystinuria. The book opens with a solid chapter on the biology of connective tissue and the genetics of hereditary syndromes. The text is a scholarly treatise on a little written-about, but increasingly important field of general medicine.

Joseph Hochstadt, M.D.

The Community and Racial Crisis. Edited by David Stahl, F. B. Sussman, and N. J. Bloomfield. Practicing Law Institute, 20 Vesey Street, New York, 1966. Pp. 364. ($7.50)

At the end of 1964, New York's Practicing Law Institute held a forum on civil disobedience and protest demonstrations. Many of the participants were attorneys, some were police officers, and there was also some representation of civic and civil rights groups. This book is a record of that meeting. It includes a careful and usable chapter on police problems associated with racial tensions. Almost any intelligent reader will be interested in the section dealing with laws against discrimination — their historical development and the problems of interpretation and enforcement. Another useful chapter is the one on the community resources available in resolving racial crises. The book, as a whole, is a road map through a complex jungle of laws, ideals, regulations, and hopes. It also offers a systematic examination of the community relations approach to its topic.

Henry A. Davidson, M.D.

Homemaking For The Handicapped. E. E. May, N. R. Waggoner and E. M. Boettke. New York, 1966, Dodd, Mead and Company. Pp. 206. Illustrated ($7.50)

Would you know how to sew a dress for a little girl that would minimize the fact that she was wearing braces? How a woman using a crutch can bring the clothes out of the house and hang them on a line? How a one-armed man can open a tin can?

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William Schramm, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

OCTOBER, 1966 • VOL. XXXIX, NO. 8

In a Brooklyn, N.Y., study, the incidence of infection with drug-resistant tubercle bacilli was found to be higher in children than in adults. One factor may be that children in depressed areas were infected by adults whose organisms had become resistant during treatment.

PRIMARY TUBERCULOSIS IN CHILDREN

The significance of the emergence of resistant strains of *Mycobacterium tuberculosis* to the three major drugs used in treating tuberculosis has been the subject of several studies in recent years.

Initial infection with drug-resistant strains is known as primary drug-resistant infection. Studies of the incidence of such infection have been made by the U.S. Public Health Service, the Veterans Administration, and the New York City Department of Health. Data from these studies, made on adults, show that the present level of tuberculous disease due to resistant strains is low, about 5 per cent or less for the three major drugs — streptomycin, isoniazid, and para-aminosalicylic acid (PAS).

However, unless the tuberculin test has recently converted to positive, it cannot be said with certainty whether the tuberculous disease in adults is the result of recently acquired infection or is due to an endogenous exacerbation of infection acquired during childhood.

Since primary tuberculosis in children represents recently acquired infection, isolation of resistant organisms from such patients prior to drug therapy affords a more nearly accurate assessment of the incidence in a community of primary drug-resistant infection than does the isolation of resistant organisms from untreated adults.

Such a survey was undertaken at the Children's Chest Service of the Kings County Medical Center to which 332 children were referred from January 1, 1961, through December 31, 1966, for evaluation either because of a recent contact with a patient with infectious tuberculosis or for treatment because of disease. The majority were from a district of low socioeconomic status where the risk of tuberculosis was high. None was more than 13 years of age.

Cultures positive for *M. tuberculosis* were obtained from gastric washings in 120. When growth of the cultures was adequate, the organisms were planted separately on medium containing each of the three drugs. A control culture contained no drug.

Two Criteria

Strains from 101 of the 120 patients were considered suitable for study. Of these, 80 patients had received isoniazid for five days or less, a time considered insufficient for the emergence of resistant strains.

The data on isoniazid were analyzed according to two criteria, that of the Public Health Service and that of the Veterans Administration. In the former, + growth in the 0.2-microgm. concentration of isoniazid is considered the lower boundary of significant resistance. By this standard, 13 of 80 strains (16.3 per cent) were resistant to isoniazid. According to the VA criteria (any growth in 5-microgm. concentration or growth in the 1-microgm. concentration of isoniazid equal to that in the control), only 5 of the 80 strains (6.3 per cent) were resistant to isoniazid.

Morris Steiner, M.D., and Amor Cosio, M.D. *The New England Journal of Medicine*, April 7, 1966.

None of the patients had received streptomycin prior to the isolation of the organisms. With the criteria of either the PHS (+ + + growth in 10-microgm. concentration), or the VA (+ + + + growth in 10-microgm. concentration), only three of 101 strains tested were significantly resistant.

As for PAS, three of 101 strains (3.0 per cent) were resistant by the PHS criterion (+ growth in 10-microgm. concentration); and only one strain by the VA criterion (+ + + + growth in 10 microgm. concentration).

Only two cases of multiple-drug resistance were found, one to isoniazid and PAS and one to all three drugs.

Studies Compared

While the findings of this study cannot be compared with those of the PHS and VA studies because of the vastly different population groups, there is basis for comparison with a study conducted among adults in New York City in which an incidence of primary isoniazid resistance of 2.6 per cent was reported, as compared with 6.3 per cent in this study.

The lower incidence in the adult group may be accounted for in part by the "dilution" of recently acquired primary resistance with endogenous reinfection. Since none of the patients in the present study was more than 12 years of age and 75 per cent were four years of age or younger, this factor was eliminated.

Furthermore, patients in the present study were drawn mainly from a local area of depressed socioeconomic status and of high risk for tuberculosis. It is likely that the greater incidence of primary isoniazid-resistant infection in these patients as contrasted with the adult group represents contact infection with individuals in the community whose organisms had become resistant during treatment.

Since the adult population in a community is a source of infection for children, it is perhaps surprising that the incidence of primary drug resistant infection was not greater in the present study. This may be because the children were infected with drug-sensitive organisms before the organisms of the source case had become resistant as the result of incomplete therapy. Another explanation may be that a large proportion of the adults in the earlier study were of a less socially responsible group (skid-row alcoholics) who had little close contact with children.

Clinical studies to denote the level of *in vivo* resistance of infecting organisms are difficult to assess. In the present study, the clinical course of the patients in whom isoniazid-resistant strains were obtained was no different from those in whom sensitive strains were found. Both groups were treated with isoniazid and PAS and there were no deaths in either group. Although success in treatment is not a sufficient criterion of the significance of resistance tests, it should be remembered that the mortality rate in children with active primary disease before chemotherapy was high.

From a theoretical point of view, there are two major differences between acquired and primary resistant infections.

In acquired resistance the process of selection and multiplication of the resistant mutant occurs in the patient himself, the interpretation being that sufficient concentration of the drug is not present to prevent multiplication of the organisms. In primary resistant infection the process of selection and multiplication of the resistant mutant has occurred elsewhere than in the patient. It therefore does not necessarily mean that the patient cannot cope with such a strain if sufficient concentration of the drug can be achieved in the blood.



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*Marks, V., and Dawson, A.: Brit. M. J. 1:293, 1965.



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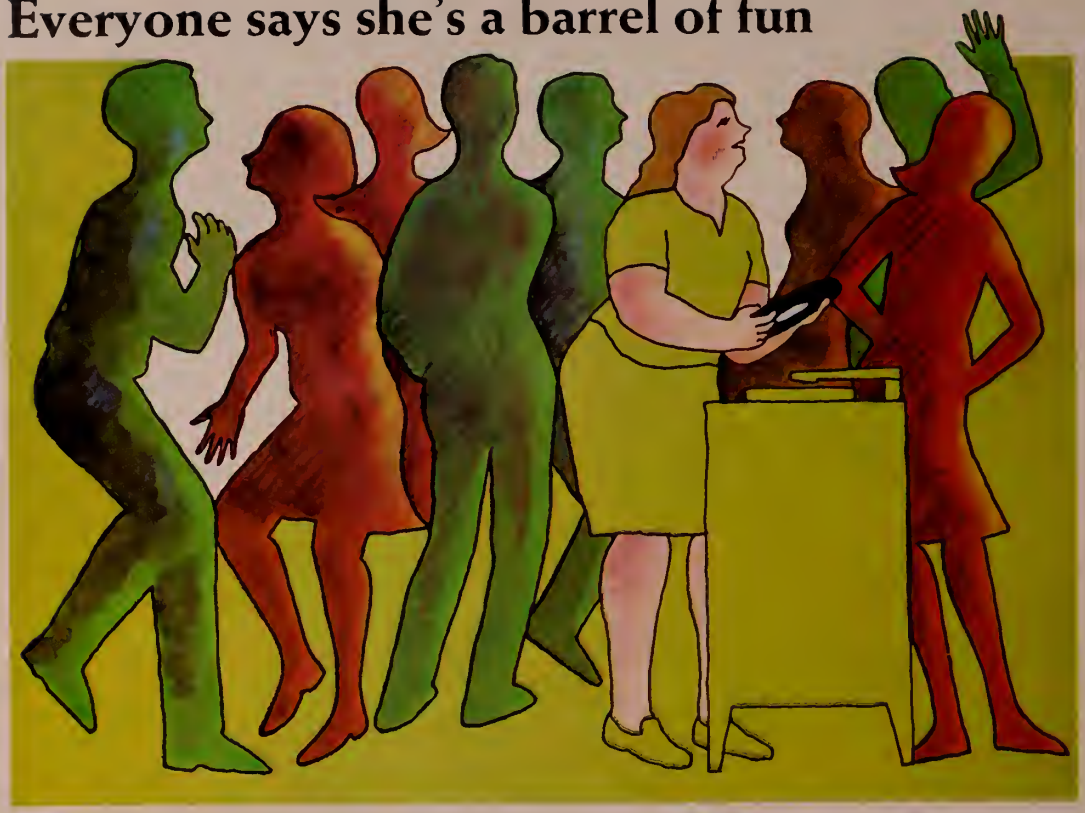
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Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are comman and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libida, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

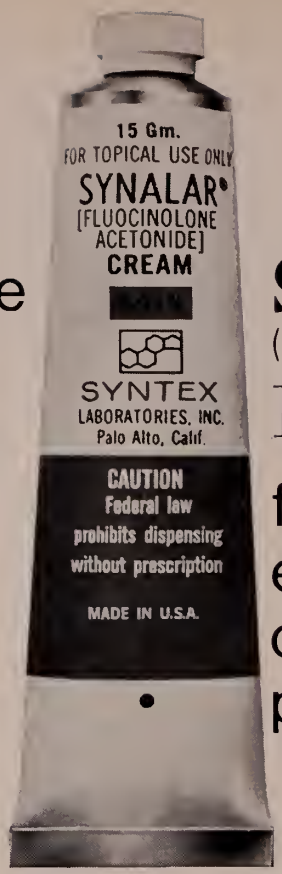
Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculapapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneuratic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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the superiority topical with the

Now you can prescribe as little or as much Synalar Cream 0.01% as is needed for a particular therapeutic problem in a size that permits the greatest economy for your patient. The new 15 Gm. tube, for example, is best suited for short-term therapy and for small sites. For more extensive body areas prescribe the 45 Gm. tube—a size that's also ideal for your treatment table. And the 120 Gm. jar is most economical for hospital use. Thus, with Synalar Cream 0.01%, you have the superiority of a modern topical corticosteroid shown to be more effective than 1% hydrocortisone[1-3] plus the economy that makes therapy practical for use in more dermatologic conditions, in long-term maintenance, with occlusive dressings in resistant cases, and in extensive area involvement.

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** 1. *General*—Synalar Cream 0.01% is virtually nonsensitizing and nonirritating. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. 2. *Occlusive dressing method*—With occlusion of extensive areas, systemic absorption of the corticosteroid may occur, and suitable precautions should be taken. Occasional patients may show contact sensitivity to a particular dressing material or adhesive. Miliaria, folliculitis, or pyodermas have been seen infrequently with the use of this technique. The development of infection requires appropriate antibacterial therapy and discontinuation of the occlusive dressing method. Local atrophy and striae have been reported with protracted occlusive dressing therapy. While lesion relapses can be expected to occur in many psoriatic patients, remissions may persist for several weeks to several months in favorable cases. The patient whose psoriasis is in an active stage, with recent appearance of new lesions, may not be a good candidate and may show early relapse. Some plastic films may be flammable, and due care should be exercised in their use. Similarly, caution should be employed when such films are used on or left near children to avoid the possibility of accidental suffocation. **Side Effects:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. **References:** 1. Cahn, M. M., and Levy, E. J.: J New Drugs 1:262 (Nov.-Dec.) 1961. 2. Meenan, F. O.: J Irish Med Ass 52:75 (Mar.) 1963. 3. Robinson, H. M., Jr., Raskin, J., and Dunseath, W. J. R.: Southern Med J 56:797 (Jul.) 1963.

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Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

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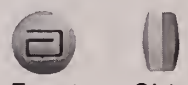
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Methamphetamine Hydrochloride in Long-Release Dose Form



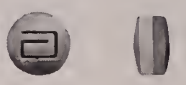
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DESBUTAL 10 Gradumet
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60 mg. Pentobarbital Sodium



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Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

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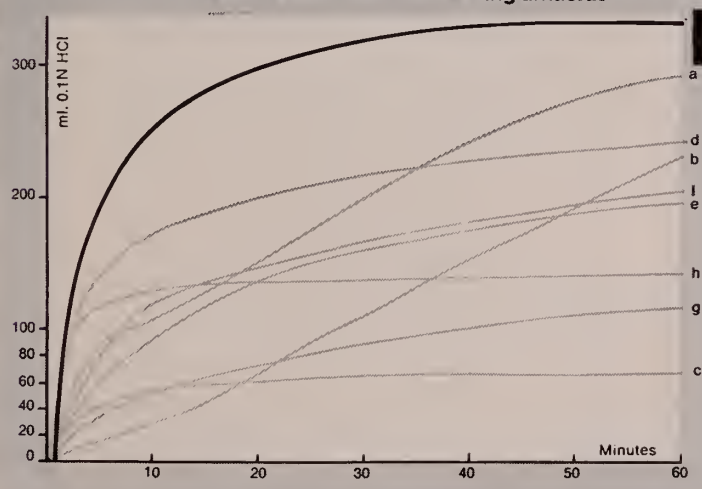
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New WinGel neutralizes 300 times its active-ingredient weight in 0.1N hydrochloric acid—neutralizes more acid faster than other leading antacids



Rate of 0.1N hydrochloric acid neutralization at pH 3.5 and 37° with WinGel and eight other leading antacid tablets—*in vitro*. Samples equaled the weight of tablet material containing 1.0 Gm. active ingredients.*

*Hinkel, E. T., Jr. (New York): Data in the files of the Department of Medical Research, Winthrop Laboratories.

Dosage: Peptic ulcer or gastritis—from 2 to 4 teaspoons of WinGel liquid or 2 to 4 tablets chewed or allowed to dissolve in the mouth every two to four hours. **Gastric hyperacidity**—2 tablets or teaspoons about ½ to one hour after meals as needed; children from 7 to 14 years of age, 1 or 2 tablets or 1 or 2 teaspoons of liquid as needed.

How Supplied: Liquid in bottles of 8 fl. oz. and 1 pint. **Tablets** in cellophane strips, boxes of 50 and 100. (One teaspoon of WinGel liquid is equivalent to one WinGel tablet in acid-combining capacity.) WinGel, trademark reg. U.S. Pat. Off.

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Finally — a taste your patients will truly like

(1058M)

Behind continued high blood pressure readings lies the possibility of organic damage[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.



"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,[15-17] since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: 1. Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. **2.** Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. **3.** Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. **4.** Berkson, D. M.: Indust. Med. & Surg. **32**:371, 1963. **5.** Cohen, B. M.: M. Times **91**:645, 1963. **6.** Lee, R. E., et al.: Am. J. Cardiol. **11**:738, 1963. **7.** Moyer, J. H.: Am. J. Cardiol. **9**:821, 1962. **8.** Moser, M.: New York J. Med. **62**:1177, 1962. **9.** Wood, J. E., and Battey, L. L.: Am. J. Cardiol. **9**:675, 1962. **10.** Moyer, J. H., and Heider, C.: Am. J. Cardiol. **9**:920, 1962. **11.** Moser, M., and Macaulay, A. I.: New York State J. Med. **60**:2679, 1960. **12.** Judson, W. E.: Nebraska M. J. **44**:305. 1959. **13.** Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. **1**:5218, 1961. **14.** Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. **15.** Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. **10**:516, 1962. **16.** Reid, W. J.: J. Am. Geriatrics Soc. **13**:365, 1965. **17.** Feldman, L. H.: North Carolina M. J. **23**:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

RAUTRAX®-N

Squibb Rauwolfia Serpentina Whole Root (50 mg.) with Bendroflumethiazide (4 mg.) and Potassium Chloride (400 mg.)



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



Sustained circulatory, respiratory and cerebral stimulation for the

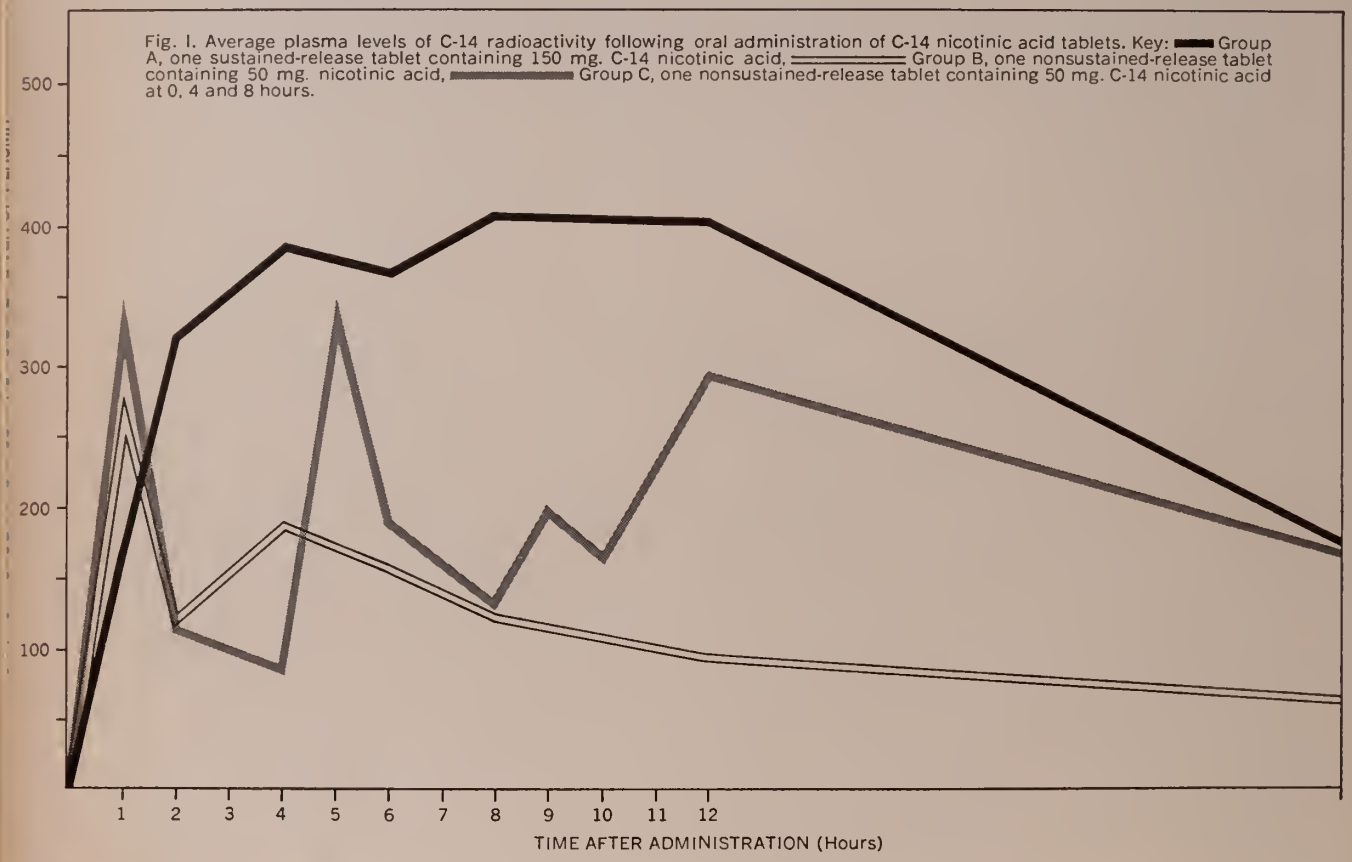


Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.



(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated

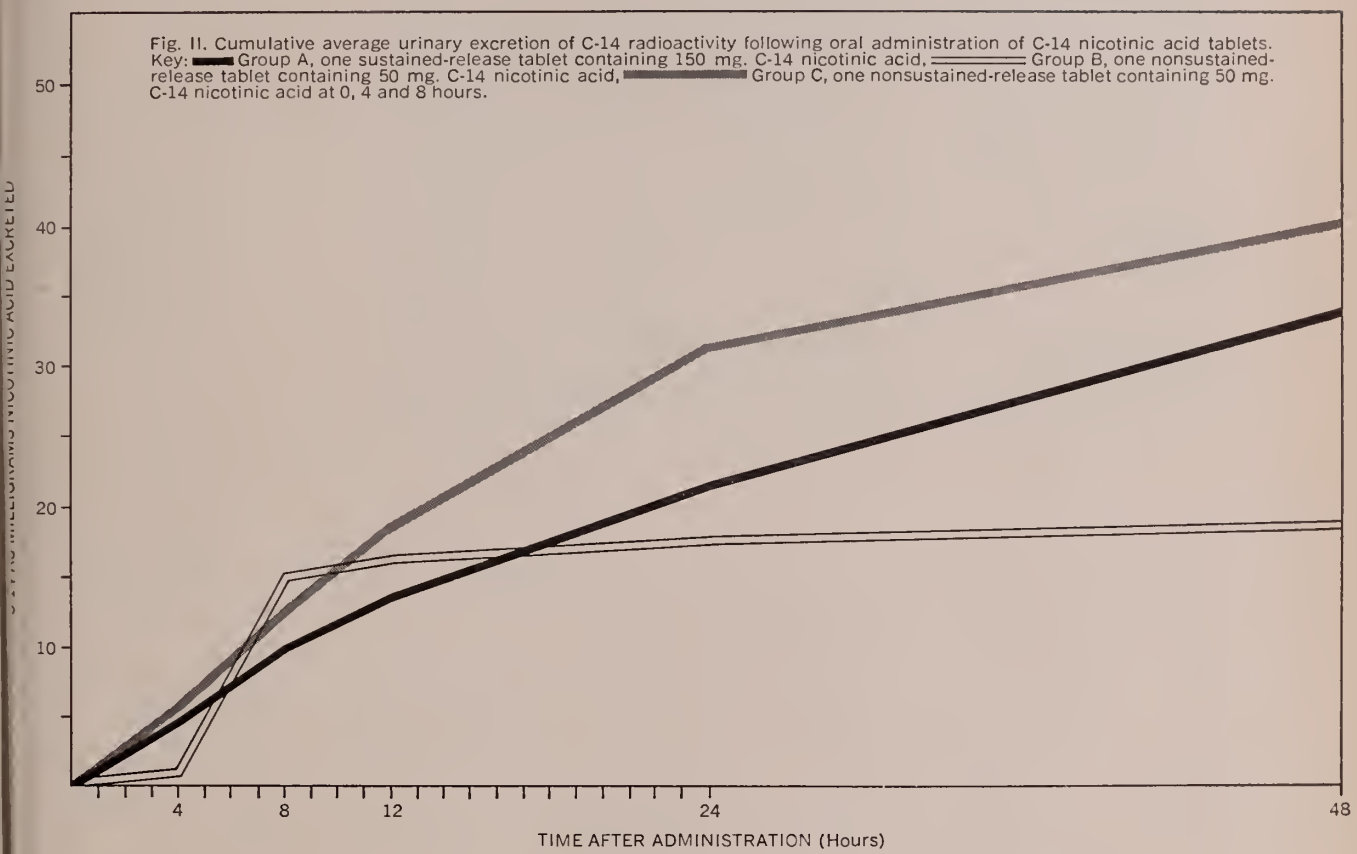


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

ess confused and moody. Personal care, memory, motional stability, social attention improve. Fatigue, pathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will ermit your patients to enjoy the benefits of time-rolonged nicotinic acid/pentylenetetrazol therapy, t an economical price. Dosage is only one tablet every 2 hours.

ontraindications: There are no known contraindications.

recautions: Exercise caution when treating patients ith a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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SYMPOSIUM ON ADOLESCENCE

NEW ORLEANS, LOUISIANA — **DECEMBER 1-3, 1966**

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Enclosed is my registration fee of $20 for the SYMPOSIUM ON ADOLESCENCE to be given December 1-3, 1966 at the Fontainebleau Motor Hotel. (Checks should be made payable to Touro Infirmary.)

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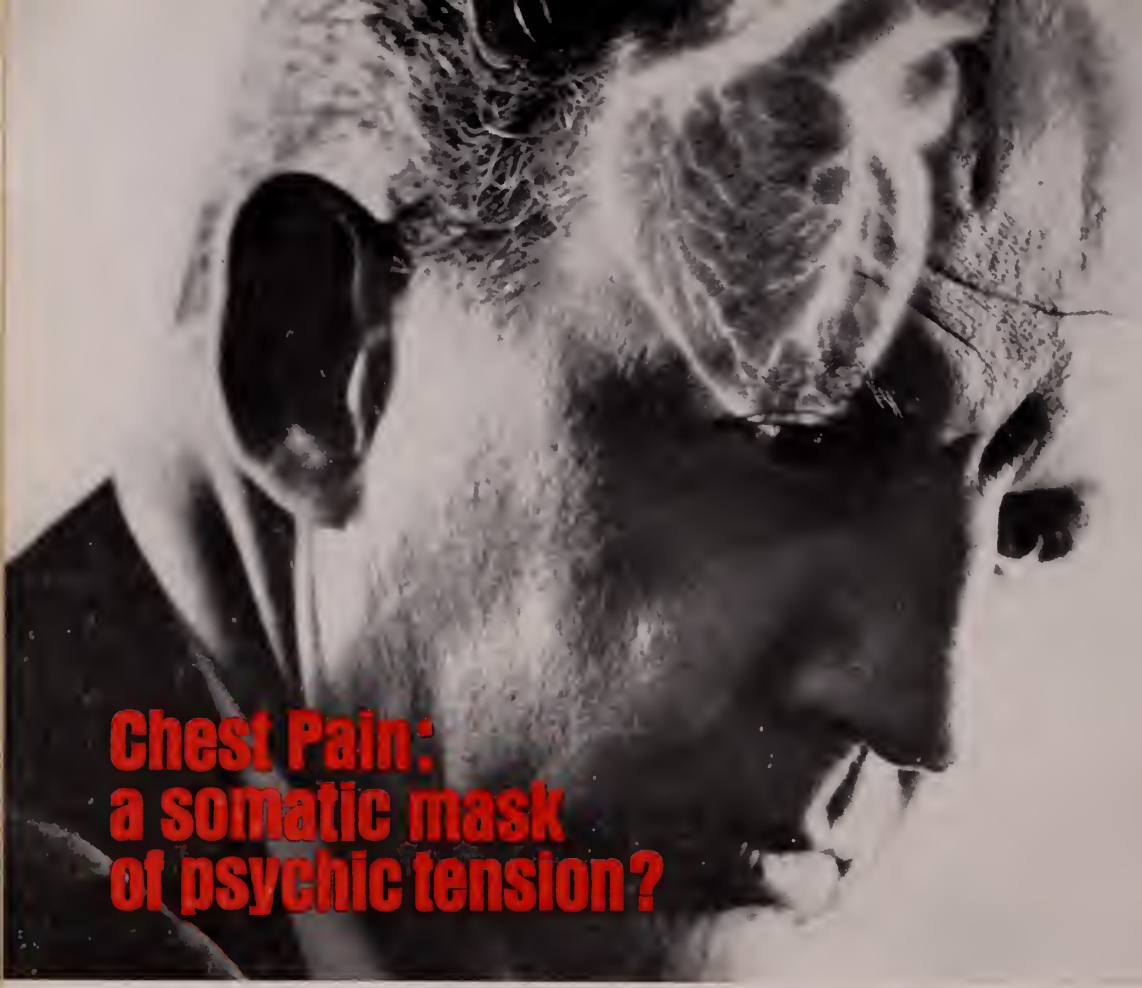
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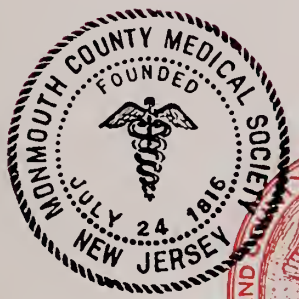
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CONTENTS • Pages 495 to 542

EDITORIALS
The Healing Art 495
The Return of the Plagues 495
Medication, Auto Accidents, and the M.D.'s Responsibility 496
November is Life Month 497

ORIGINAL ARTICLES
Dr. Sprague's Role in the History of MSP
Irving P. Borsher, M.D., Newark 498
Surgery for Peptic Ulcer
Augustus L. Baker, Jr., M.D., Dover 502
Spontaneous Hemopneumothorax
Franklyn P. Gerard, M.D., Newark and Adrian M. Sabety, M.D., East Orange 506
Rehabilitation of the Disabled Worker
Jarvis Smith, M.D., Trenton 509
Honor A Physician?
Humphry Osmond, M.D., Princeton 512
Social Phenomena and the Physician
Ralph Straetz, Ph.D. and Elena Padilla, Ph.D., New York, New York 519
Health Care Demands In Modern Medical Practice
Morton D. Bogdonoff, M.D. and Claude R. Nichols, M.D., Durham, North Carolina 522

STATE ACTIVITIES
Trustees' Minutes: September 18, 1966 527
August 21, 1966 529
Ownership Statement 531
Physicians Seeking Locations 532
Communities Seeking Physicians 533
Letters to THE JOURNAL 534
The 1967 Annual Meeting 534
ANNOUNCEMENTS 535
OBITUARIES 537
BOOK REVIEWS 538
RESPIRATORY DISEASE ABSTRACTS 541

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In its bicentennial year, the official seal of The Medical Society of New Jersey shares prominence with the official seals of those component societies celebrating their sesquicentennial anniversaries. According to the proceedings of the New Jersey Historical Society ("An Outline of the History of the Medical Society of New Jersey to 1900"), the first county medical societies organized in 1816 were: Somerset, May 21; Essex, June 4; Cumberland, June 6; Middlesex and Morris, June 11; and Monmouth, July 24.

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vignettes of angina pectoris —
no. 1 in a series:

angina and the surgeon

John Hunter —
British surgeon (1728-1793)

angina of anger

"My life is in the hands of any rascal who chooses to annoy and tease me."[1] So said the great British surgeon and anatomist, John Hunter, realizing that he could not control the anger which precipitated frequent and severe attacks of angina pectoris. According to Mettler: "His statement was no exaggeration. On October 16, 1793, he attended a meeting of the St. George's hospital staff, and, while defending the interests of several students, he was contradicted and thoroughly antagonized. The pains of angina commenced, he started toward another room, gained it, and fell dying into the arms of a physician."[2]

Why Edward Jenner withheld his paper on angina In 1777, at an earlier stage of the condition, Hunter's angina alarmed a favorite pupil, Edward Jenner, who wrote to Dr. Heberden that he feared his teacher was "affected with symptoms of the Angina Pectoris."[3] So concerned was Jenner about his former teacher's emotion-related condition that he deliberately cancelled publication of a paper on angina pectoris, fearing that Hunter would read it, and have "his fears excited by its truly formidable nature."[4]

Severity of angina described Hunter's brother-in-law, Dr. Everard Home, who witnessed his death and performed an autopsy, gave this account of the later stage of the condition:

"...the pain became excruciating at the apex of the heart; the throa was so sore as not to allow of an attempt to swallow anything and the left arm could not bear to be touched.....

"The affections above described were, in the beginning, readily brought on by exercise... but they at last seized him when lying in bed, and in his sleep...."[5]



18th century ancestor of the modern coronary candidate
Surgeon, anatomist, pathologist, physiologist, geologist, and teache Hunter had a passion for research which led him to disregard his practice, his health and even the

law. When the Irish giant O'Brien learned that Hunter desired his skeleton for a museum, he willed that his body be sunk at sea in a lead coffin. But Hunter was not to be denied. According to Major, he "...bribed the watchers and finally obtained the body at a cost of 500 pounds although he had to borrow the money to pay the men."[3]
In 1767, he experimentally inoculated himself with gonorrhea and syphilis, treated himself with mercury for three years, and was apparently cured.[5] Hunter had feelings of inadequacy about his education and speaking ability, but this did not prevent him from being hard driving and abrupt with his colleagues. His competitiveness with his physician older brother was also well known, and ended in complete estrangement between the two men.[2,3] Today, the personality traits seen in John Hunter are recognized to be important predisposing factors in the development of coronary artery disease—often manifested as angina pectoris. According to Friedman and Rosenman,[6] in a group of men whose behavior was characterized by intense ambition and competitive drive, a greater than average incidence of angina pectoris was among those abnormal conditions noted.

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Actions: The exact cause of angina pectoris (that is, the pain associated with coronary artery disease) remains obscure, despite the numerous and often conflicting hypotheses concerning its pathophysiology. Therapy at the present time, therefore, remains essentially empiric. Customarily, clinical improvement has been measured by: reduction in (1) number, intensity and duration of angina pectoris attacks and (2) necessity for glyceryl trinitrate intake for prevention or relief of anginal attacks.

Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. has been reported in clinical usage to reduce in number and severity the incidence of angina pectoris attacks, with concomitant reduction in glyceryl trinitrate intake.

In the evaluation of Peritrate (pentaerythritol tetranitrate) and Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. in angina pectoris, clinical improvement has been customarily measured subjectively by reduction in number and severity of attacks and necessity for glyceryl trinitrate intake for prevention or abortion of anginal attacks. Individual patterns of angina pectoris differ widely as does the symptomatic response to antianginal agents such as pentaerythritol tetranitrate. The published literature contains both favorable and unfavorable clinical reports. In conjunction with total management of the patient with angina pectoris, Peritrate (pentaerythritol tetranitrate) and Peritrate SA Sustained Action (pentaerythritol tetranitrate) 80 mg. have been accepted as safe for prolonged administration and widely regarded as useful.

Animal pharmacology: In a series of carefully designed studies in pigs, Peritrate (pentaerythritol tetranitrate) was administered for 48 hours before an artificially induced occlusion of a major artery and for seven days thereafter. The pigs were sacrificed at various intervals for periods up to six weeks. The result showed a significantly larger number of survivors in the drug-treated group. Damage to myocardial tissue in the drug-treated survivors was less extensive than in the untreated group. Pigs rather than dogs were used because their coronary artery distribution more closely resembles that of human beings. Studies in dogs subject to oligemic shock through progressive bleeding have demonstrated that Peritrate (pentaerythritol tetranitrate) is vasoactive at the postarteriolar level, producing increased blood flow and better tissue perfusion. These animal experiments cannot be translated to human behavior

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MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors—in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9, 10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

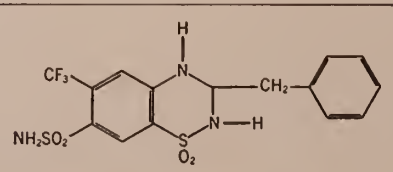
Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.



Contraindications: Severe renal impairment; previous hypersensitivity.

Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: **1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.

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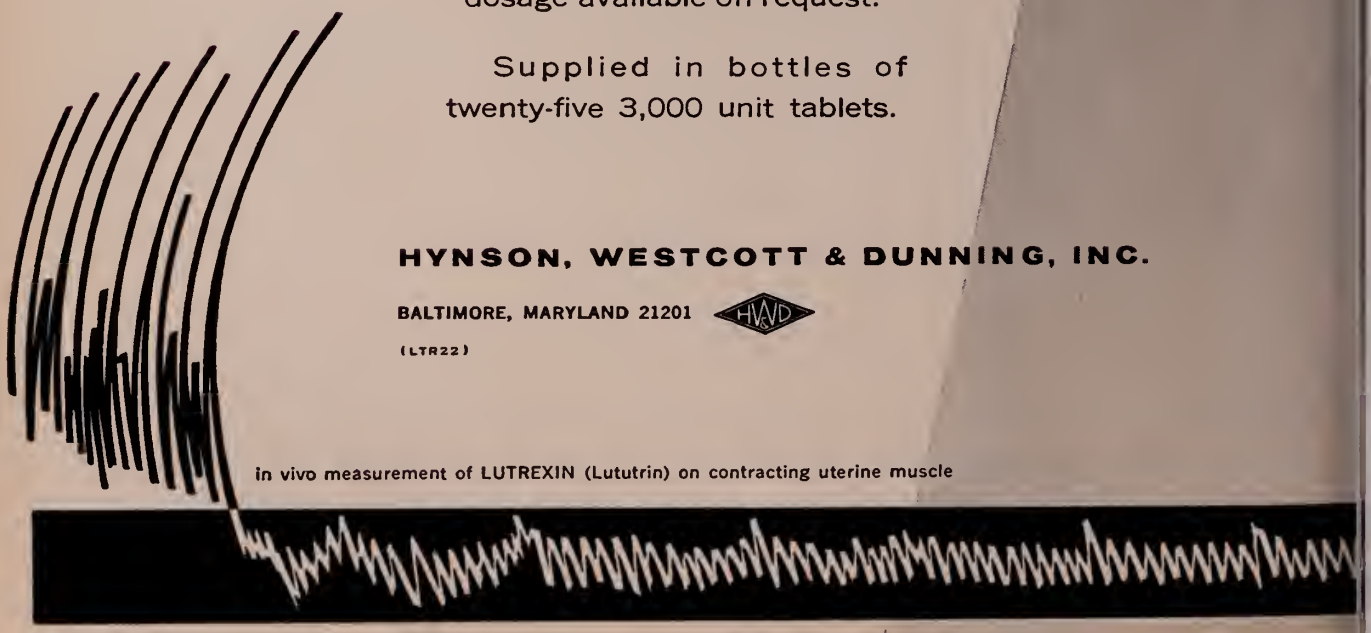
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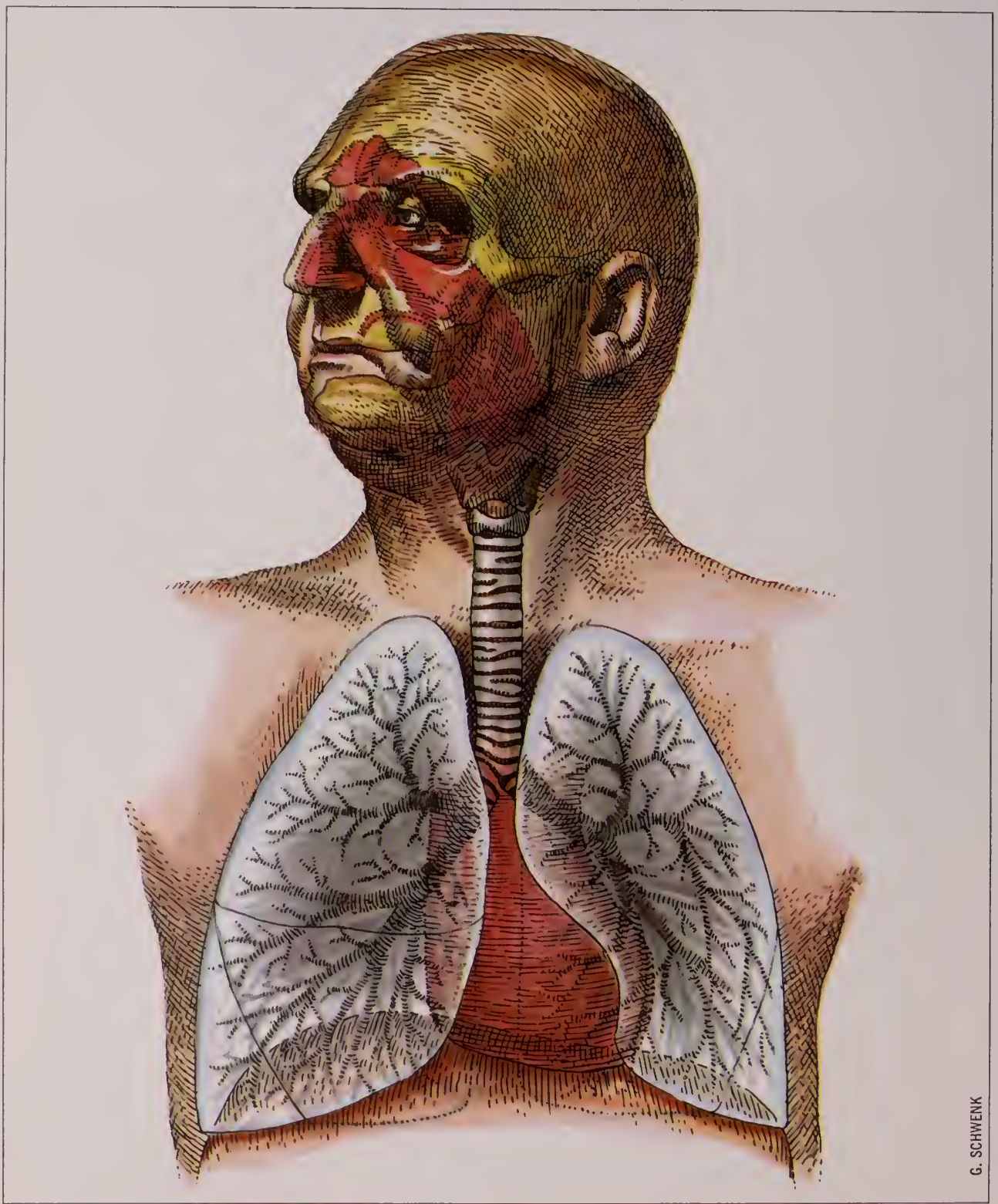
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this issue: the common cold and the aging patient

the common cold and the aging patient

Louis J. Vorhaus, II, M.D., F.A.C.P.



Effects of aging on the anatomic and physiologic aspects of the respiratory apparatus.

The chest becomes more fixed, less mobile and less elastic as the bronchial walls and thoracic ligaments lose elasticity. The diaphragm and intercostal muscles atrophy and weaken. The lungs become smaller, flabbier and weigh less, decreasing vital and total lung capacity, increasing residual volume and the alveolar dead space.

Sir William Osler described pneumonia as the welcome friend of the aged patient, because the patient with pneumonia usually died quietly. But today, the well-informed physician is an even better friend of the aging patient, since it is better to live than to die, no matter how quietly.

One of the first avenues of approach in the control of the hazards of respiratory disease in the aging patient is prompt and proper attention to the common cold or upper respiratory infection. The common cold may be the first step in the relatively short path to lower respiratory infection, broncho-pneumonia and death. This train of events occurs frequently among older persons. Indeed, pneumonia is one of the most common causes of their admission to hospitals and ranks high on the list of geriatric killers. Colds are more debilitating in elderly people and the aged are more likely candidates for secondary infections such as sinusitis and bronchitis. These infections, in turn, are more prone to lead to bronchopneumonia, because of lowered resistance and anatomic and physiologic changes in the lungs of the elderly.

What is different about the respiratory tree of an aged person and that of an otherwise healthy younger adult? Aging certainly takes its toll on all parts of the body, affecting both anatomic and physiologic aspects of the respiratory apparatus. These changes are in part due to the wear and tear that occurs over the years; the repeated bouts of respiratory infection, long exposure to atmospheric pollutants, to occupational inhalants, smoking, malnutrition, obesity, inactivity and the development of other diseases which may affect the lungs.

With the passage of years, the lungs change. They become scarred and emphysematous and lose their compliance. The whole chest becomes more fixed, less mobile and less elastic.

The anatomic changes that occur in aging render the lungs less efficient. Tests of pulmonary function in senescence show a deterioration characterized by a decrease in vital capacity and total lung capacity, an increase in residual volume and alveolar dead space. Maximum breathing capacity is reduced and uniformity of ventilation deteriorates. These problems are often aggravated by the obstructed breathing, fever and secondary infection associated with the common cold, placing an additional stress on the entire cardiopulmonary reserve.

In addition, the efficiency of a cough is below par in older persons even though they are in good health. This is partly due to the decreased respiratory excursions and distensibility of the chest wall, and partly from loss of elasticity of bronchial walls which tend to make them collapse in a cough.

The elderly patient's resistance to infection is often reduced. Nutritional deficiencies are more common in aged people. There is some evidence to indicate that their capacity to respond to stress is less efficient. Finally, there is often relatively meager symptomatic response to acute disease. The absence of obvious or dramatic clinical signs and symptoms of severe illness is particularly dangerous because, coming as it

(concluded on following page)

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does in a person whose defenses are weakened both locally and systemically, pulmonary disease may progress rapidly to irreversible stages before medical attention is sought. Respiratory infection is especially hazardous because the aged patient responds badly to hypoxia. Not only is his response to oxygen lack impaired, but the work of breathing, due to decreased compliance of the lung and increased stiffness of the thorax, is markedly augmented.
Many patients late in life are in a precarious and delicate cardiopulmonary balance which is easily decompensated from relatively minor insults such as colds and upper respiratory infections.

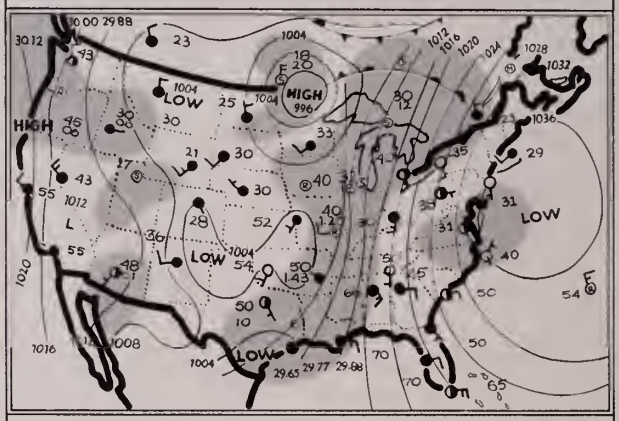
For all of these reasons, geriatricians long have stressed the importance of preventing respiratory insults. Today we have better ways of treating respiratory infection, improved techniques for clearing the lungs and bronchial tubes of secretions and better understanding of ways of improving ventilation. We possess a broader spectrum of antimicrobial agents including newer ones to deal with previously resistant organisms. Even so, the death rate from pneumonia is high in older people, and it is preferable to avoid the disease than to treat it. To do so, attention must be paid to the general maintenance of good health and all that implies, as well as to the prevention, elimination and treatment of associated conditions that predispose to or cause pneumonia such as chronic upper or lower respiratory infection, respiratory allergy, chronic sinusitis and exposure to inspired irritants.

Colds and other minor respiratory infections, which favor the development of broncho-pneumonia, should be treated vigorously and promptly, particularly those patients whose aging process has been accompanied by the development of chronic pulmonary disease. Upper respiratory passages should be cleared with decongestants. Sinuses should be drained adequately. And, when indicated, appropriate antimicrobial therapy should be instituted before serious infection of the lower respiratory tree supervenes.

In decades past it was understandable that physicians welcomed pneumonia for the aged patients because it offered them a quiet and peaceful demise. Today we recognize that in many cases, peaceful as it may have been, such deaths were often avoidable. With the current knowledge and understanding of the problems that respiratory infections impose on aging people, vigilant medical attention can often restore them to a vigorous, rewarding and productive life so that the many opportunities that exist today for people to enjoy their golden years are realized and not stolen by untimely death.

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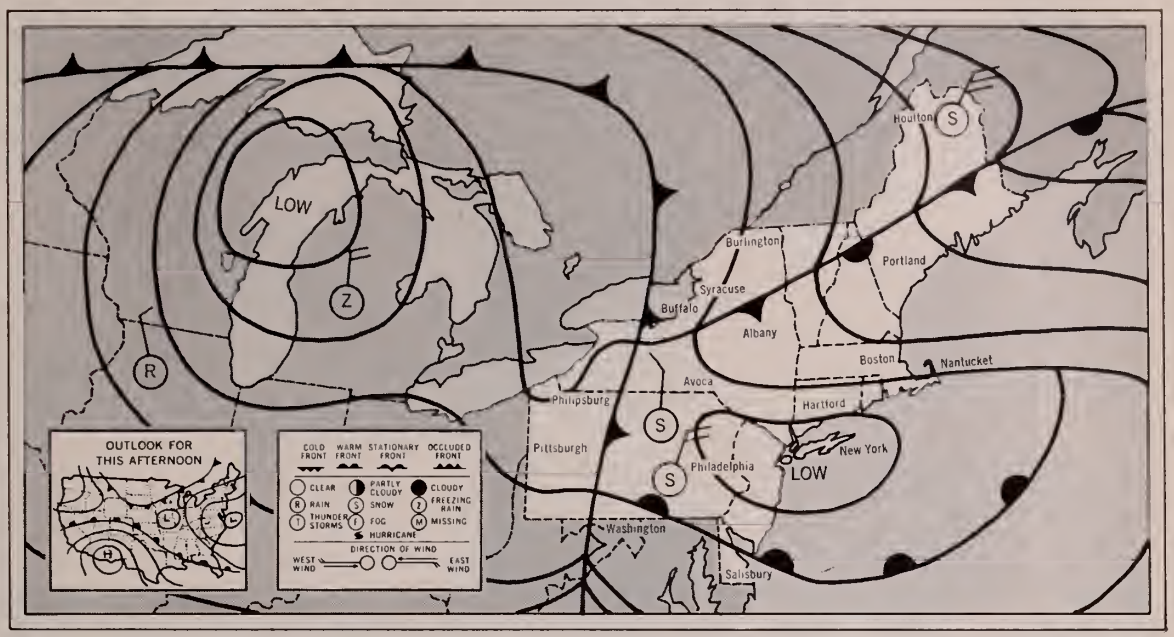
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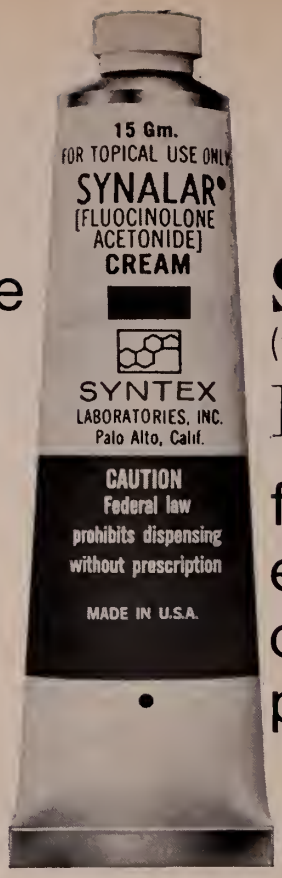
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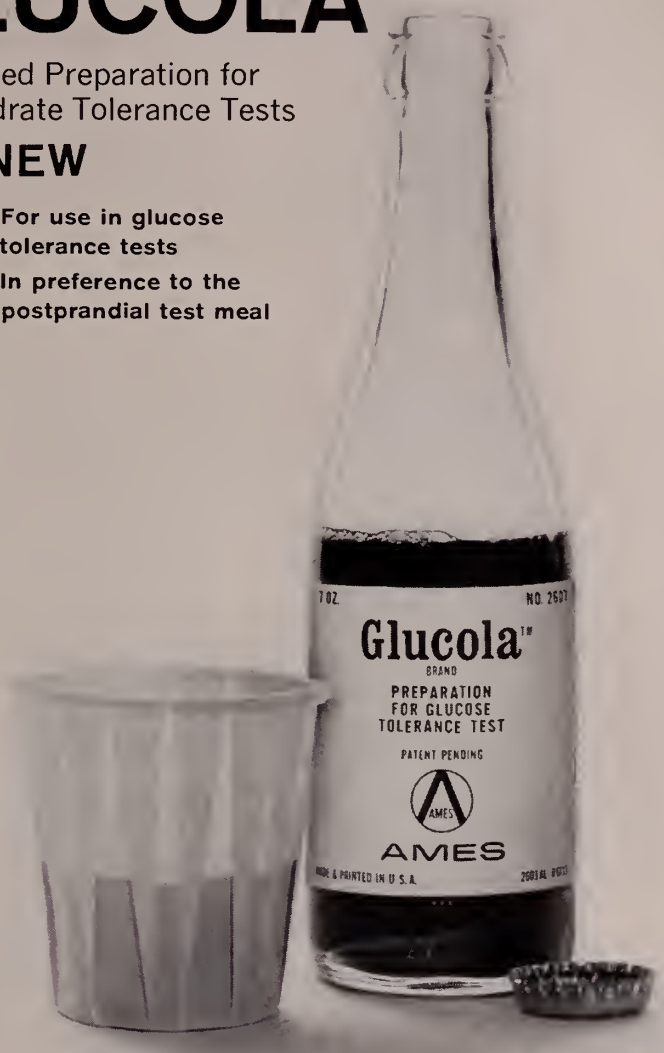
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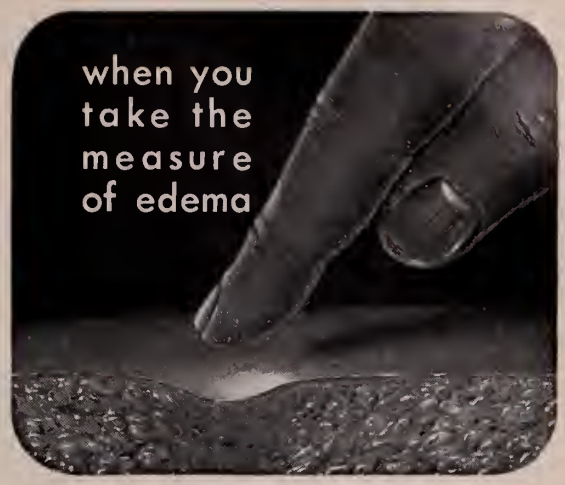
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AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur.

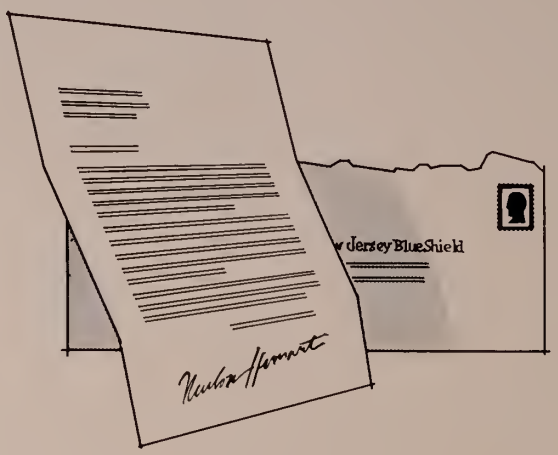
Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

Before prescribing or administering, read the package insert or file card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.

S.J. TUTAG & COMPANY
Detroit, Michigan 48234



"One does not understand fully or appreciate anything until the need is there."

It's human nature not to understand fully or appreciate something like Blue Shield protection *until the need is there*. But when that time comes, people do understand and appreciate Blue Shield's help — like the grateful Morristown subscriber whose letter is quoted.

Because it is our Participating Doctors who make Blue Shield protection possible, we pass along to them those words of appreciation, plus these others we have received.

"The sum was considerable, and had I to meet it out of my income it would have been very inconvenient . . . so I thank you warmly for taking care of me so silently and well."

"I think yours is one of the most wonderful services that can be rendered to people with moderate salaries. I could go to the hospital with a comparatively free mind knowing my doctor bills would be covered. This is a comfort and help in recovery."

"I would like to let you know how thankful I am that we belong to your Plan. We just had a new baby, and it was really a joy not to have to worry about doctor bills."

"The Medical-Surgical Plan is marvelous. This is my first participation — I am impressed. I have been singing your praises to all my friends."

"Recently, our oldest boy had a terrible accident. Thank God we had Medical-Surgical Plan. That was one thing we didn't have to worry about. It would have taken years for us to pay for it. I would recommend this Plan to everyone."

"It's wonderful to know that you folks are standing by when illness comes. Those doctor bills would be very hard to meet alone. I would never think of not belonging to the Medical-Surgical Plan of New Jersey. It is so necessary to my peace of mind."

(Excerpts from letters in our files.)

BLUE SHIELD
MEDICAL-SURGICAL PLAN ®
OF NEW JERSEY
500 Broad Street, Newark

TRENTON NEWARK CAMDEN MORRISTOWN



And now . . . for all you cold sufferers who've been looking for a cure-all.

They can't cure a cold. We can't cure a cold. You can't cure a cold. But what you can do is relieve the symptoms, making the patient comfortable and the cold bearable.

The patient suffering from head cold congestion, for instance, should breathe easier when you prescribe Novahistine LP.

Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. Two tablets in the morning and two in the evening will provide around-the-clock relief by helping to keep congested air passages clear, thus enabling your cold patient to enjoy normal and free breathing.

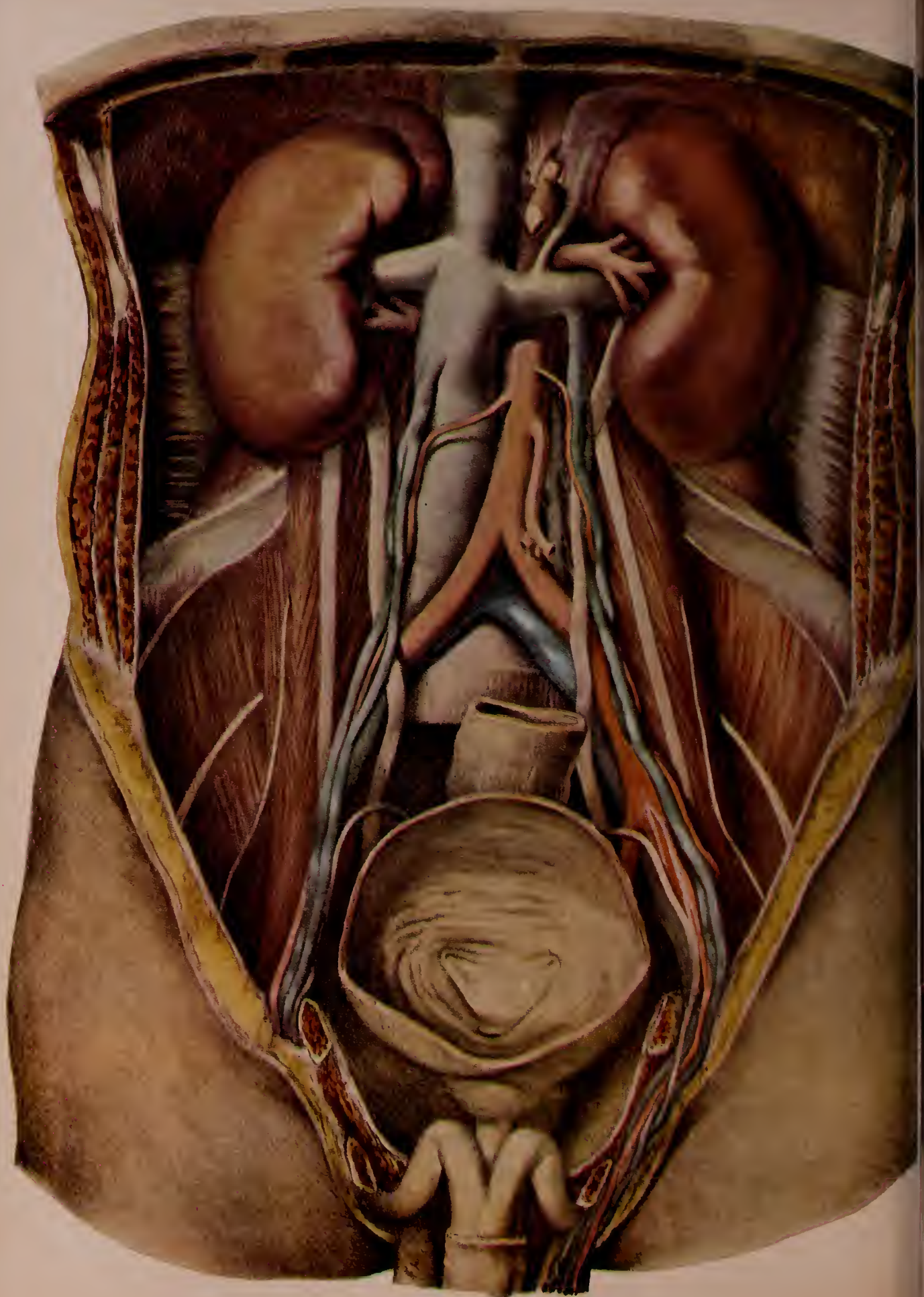
Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Tell patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis DOW

NOVAHISTINE® LP

For relief of nasal congestion.



Wide-range bactericidal action for genitourinary infections

NEW OMNIPEN® (AMPICILLIN) WYETH

A penicillin that exhibits effectiveness within the gram-positive spectrum of penicillin G* and the gram-negative spectrum of chloramphenicol and the tetracyclines.*

Active at foci of infections—kidney, ureter, bladder or urethra.

Effective against many gram-negative and gram-positive pathogens—thus may be valuable not only in genitourinary but also in common respiratory and gastrointestinal infections.

Normally produces high and persistent levels in blood and high concentrations in bile and urine.

Significant inherent stability.

**Exclusive of penicillinase-producing bacteria.*

Indications: Urinary tract infections, especially those caused by *E. coli*, *Proteus mirabilis*, and *Streptococcus faecalis* and *viridans;* respiratory infections caused by *H. influenzae*, pneumococci, streptococci, and nonpenicillinase-producing staphylococci; and gastrointestinal infections caused by *Shigella* and *Salmonella*, including *Sal. typhosa*.



Contraindications: Hypersensitivity to penicillin; infections due to penicillinase-producing staphylococci and other penicillinase-producing bacteria.

Precautions: If allergic reaction occurs, discontinue ampicillin and administer epinephrine, corticosteroids, antihistamines and/or pressor amines as indicated. Transient moderate elevation of SGOT values of undetermined significance was noted in a few infants. Liver and kidney function as well as hematopoietic tests are advisable during therapy, particularly in infants. As with other antibiotics, precautions should be taken against gastrointestinal superinfection. Safety for use in pregnancy has not been established.

Adverse Reactions: Occasional mild side effects as urticaria, skin rash, pruritus, diarrhea, nausea and vomiting. There have been no reports of blood dyscrasias, liver or kidney damage. Anaphylaxis has been reported.

Composition: Capsules, 250 mg.

American Hospital Formulary Service Category No. 8:12.16.

Wyeth Laboratories Philadelphia, Pa.

Wyeth® SERVICE TO MEDICINE

For he's a jolly good fellow



But what does he think?



Many overweight patients can benefit from the appetite control provided by the sustained anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action of amphetamine; tranquilizing action of meprobamate; prolonged action through sustained release of active ingredients.

Bamadex® Sequels®

DEXTRO-AMPHETAMINE SULFATE (15 mg.) WITH MEPROBAMATE (300 mg.) SUSTAINED RELEASE CAPSULES

to help establish a new dietary pattern

Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Lederle

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A Division of American Cyanamid Company,
Pearl River, New York

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IMPORTANT FACTS

about

Professional Liability Coverage

Insurance that only covers claims based on the rendering of, or failure to render, professional services, or arising out of malpractice error or mistake in rendering professional services, is no longer adequate.

Our policy, approved and recommended by The Medical Society of New Jersey is broad enough to cover:

(1) the non-negligent as well as the negligent claim, such as arising out of duties as committee member in your society or hospital.

(2) The financial loss to a physician in attending trial as a defendant in protracted litigation.

(3) punitive damages for libel or slander.

This program, which was designed with The Medical Society of New Jersey and its legal counsel, and operated by a cooperative Loss Control Program, offers this broad protection, security and continuity of coverage.

Complete protection should not
be controlled by price.

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Behind continued high blood pressure readings lies the possibility of organic damage[1-13]

MANY OF THE aspects of essential hypertension are unpredictable—either because there are a number of mechanisms involved or because individuals differ in their responses to these mechanisms.[1]

There is one aspect of hypertension, however, that seems, in many cases, predictable. ". . . when the blood pressure is elevated to a marked degree for an adequate period of time, this in itself leads to perpetuation of the syndrome with resulting vascular damage throughout the body."[14] All too often the disease progresses until there is damage to one of three vital organs: the heart, the kidney, the brain.



"Hypertension is certainly a major factor in the genesis of coronary heart disease, and it is even more important when compounded with obesity."[4]

"[Vascular deterioration] can be clearly seen in the kidney with a degree of damage that can be measured by renal function studies."[10]

". . . most evidence suggests that reduction of blood pressure, when it is too high, not only relieves the heart of excess work but reduces vascular damage."[1]

"In short, treatment is indicated."[1]

Antihypertensive therapy will not restore the blood vessels to normal. Yet many of the vascular changes and symptoms caused by increased blood pressure may be arrested or alleviated when the blood pressure is reduced to normotensive levels.[7]

Reducing the blood pressure helps curtail further vascular damage and improves the prognosis — when damage is not too far advanced before therapy is started.[14] Essential hypertension is an indication not only for treatment, but for *early* and adequate treatment of the patient in question.

Reduce the blood pressure with Rautrax-N

Rautrax-N combines the antihypertensive-tranquilizing action of whole root rauwolfia with the antihypertensive-diuretic action of bendroflumethiazide in one convenient medication. The two drugs complement each other so that smaller doses of both are possible.

Rauwolfia combined with bendroflumethiazide is particularly effective in long-term therapy,[15-17] since beneficial effects do not diminish with continuous daily administration.

For most patients 1 or 2 Rautrax-N tablets daily are sufficient for maintenance therapy. The simplicity, convenience and economy of such a dosage schedule are of particular benefit to older patients.

References: 1. Page, I. H., and Dustan, H. P.: The Usefulness of Drugs in the Treatment of Hypertension, in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 95. **2.** Hollander, W.: The Evaluation of Antihypertensive Therapy of Essential Hypertension in Ingelfinger, F. J.; Relman, A. S., and Finland, M.: Controversy in Internal Medicine, Philadelphia, W. B. Saunders Co., 1966, p. 97. **3.** Nickerson, M.: Antihypertensive Agents and the Drug Therapy of Hypertension, in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, The Macmillan Co., 1965, p. 727. **4.** Berkson, D. M.: Indust. Med. & Surg. **32**:371, 1963. **5.** Cohen, B. M.: M. Times **91**:645, 1963. **6.** Lee, R. E., et al.: Am. J. Cardiol. **11**:738, 1963. **7.** Moyer, J. H.: Am. J. Cardiol. **9**:821, 1962. **8.** Moser, M.: New York J. Med. **62**:1177, 1962. **9.** Wood, J. E., and Battey, L. L.: Am. J. Cardiol. **9**:675, 1962. **10.** Moyer, J. H., and Heider, C.: Am. J. Cardiol. **9**:920, 1962. **11.** Moser, M., and Macaulay, A. I.: New York State J. Med. **60**:2679, 1960. **12.** Judson, W. E.: Nebraska M. J. **44**:305, 1959. **13.** Hodge, J. V.; McQueen, E. G., and Smirk, H.: Brit. M. J. **1**:5218, 1961. **14.** Moyer, J. H., and Brest, A. N.: Hypertension Recent Advances, Philadelphia, Lea & Febiger, 1961, p. 633. **15.** Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. **10**:516, 1962. **16.** Reid, W. J.: J. Am. Geriatrics Soc. **13**:365, 1965. **17.** Feldman, L. H.: North Carolina M. J. **23**:248, 1962.

Contraindications: Severe renal impairment or previous hypersensitivity. **Warning:** Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting or G.I. bleeding occur.

Precautions and Side Effects: The dose of ganglionic blocking agents, veratrum or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Caution is indicated in patients with depression, suicidal tendencies, peptic ulcer; electrolyte disturbances are possible in cirrhotic or digitalized patients. Marked hypotension during surgery is possible; consider discontinuing two weeks prior to elective surgery and observe patients closely during emergency surgery. Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression, diarrhea, weight gain, edema, drowsiness may occur. Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients, and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, rashes may occur.

Dosage and Supply: Initial dosage, 1 to 4 tablets daily, preferably at mealtime. Maintenance, 1 or 2 tablets daily. Rautrax-N is supplied as capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin®), 4 mg. bendroflumethiazide (Naturetin®), 400 mg. potassium chloride.

Also available: Rautrax-N Modified — capsule-shaped tablets containing 50 mg. Rauwolfia serpentina whole root (Raudixin), 2 mg. bendroflumethiazide (Naturetin), 400 mg. potassium chloride. Both potencies available in bottles of 100. For full information, see Product Brief.

RAUTRAX®-N

Squibb Rauwolfia Serpentina Whole Root (50 mg.) with Bendroflumethiazide (4 mg.) and Potassium Chloride (400 mg.)

SQUIBB 'The Priceless Ingredient' of every product is the honor and integrity of its maker.

New drugs take exams, too.

Today, virtually every medical school in the United States cooperates with pharmaceutical manufacturers in the clinical evaluation of new and promising drugs. Just as you might find it significantly more difficult to practice medicine without the useful new compounds made available through original pharmaceutical research in the past twenty years—prescription-drug manufacturers would find it equally difficult to obtain extensive, long-term, dependable evaluations of new therapeutic agents without the close cooperation of medical staffs and clinical facilities of medical schools and teaching hospitals. Such cooperation leads toward more effective care of more patients—the common goal of medical and pharmaceutical research—toward reduction in the cost of disease, toward increase in useful longevity.

This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

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"Yes, Doctor, the pain is gone."

■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

'Empirin'® Compound with Codeine Phosphate gr. ½ No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

Keeps the Promise of Pain Relief

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

block end runs



LOMOTIL®

tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

tackles the problem of diarrhea directly

Effectiveness—Physiologic evidence indicates that Lomotil acts directly on the smooth muscle of the bowel to lower motility and control diarrhea. This action is unsurpassed in promptness and efficiency.

Convenience—Lomotil is available as small, easily carried, virtually tasteless tablets and as a pleasant, fruit-flavored liquid.

Versatility—The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or adjunctively in diarrhea associated with:

• Functional hypermotility • Acute infections • Malabsorption syndrome • Drug therapy • Gastroenteritis and colitis • Irritable bowel • Regional enteritis • Ileostomy • Ulcerative colitis • Food poisoning

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)

Adults: 2 tsp. 5 times daily (20 mg.)
(or 2 tablets q.i.d.)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE *Research in the Service of Medicine*

when congestion is complicated by sulfa-susceptible bacterial invaders in the upper respiratory tract...



prescribe economical Trisulfaminic®

Each tablet contains: Triaminic® 25 mg. (phenylpropanolamine hydrochloride 12.5 mg., pheniramine maleate 6.25 mg., pyrilamine maleate 6.25 mg.); Trisulfapyrimidines, U.S.P. 0.5 Gm. (sulfadiazine 0.167 Gm., sulfamerazine 0.167 Gm., sulfamethazine 0.167 Gm.)

PHARMACOLOGY: Triaminic decongests and promotes drainage of nasal and paranasal passages, and prevents any further histamine-induced damage; the triple sulfonamides inhibit susceptible bacterial invaders. INDICATIONS: For congestion and infection of the upper respiratory tract caused by sulfa-susceptible organisms. DOSAGE: Adults: 2 to 4 tablets initially, followed by 2 tablets every 6 hours. Medication should be continued until patient has been afebrile for 3 days. ADVANTAGES: The advantages of Trisulfaminic in upper respiratory infections are: freedom from narcotics or alcohol; therapeutic reliability; safety; economy; ease of administration; freedom from potential sensitization to broad-spectrum antibiotics which may be reserved for lower respiratory or other infections caused by susceptible organisms. CONTRAINDICATIONS: Contraindicated in sulfonamide and antihistamine sensitivity, impaired renal function, pregnancy approaching term, and in premature infants and newborn infants during the first month of life. Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. WARNING: Use only after careful evaluation in patients with liver or renal damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions with administration of sulfonamides. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed periodically. Sulfonamide therapy may potentiate the hypoglycemic action of sulfonylureas. PRECAUTIONS: Use with caution in patients with histories of significant allergy or asthma. Assure an adequate fluid intake. Because the antihistamines may cause drowsiness of varying degree, warn patients about activities requiring alertness such as driving a car or operating dangerous machinery. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease and diabetes. ADVERSE REACTIONS: As in all sulfonamide therapy, the following reactions may occur: headache, nausea, vomiting, diarrhea, icterus, hepatitis, pancreatitis, urticaria, rash, fever, cyanosis, hematuria, crystalluria, proteinuria, blood dyscrasias, petechiae, purpura, neuropathy and injection of the conjunctiva and sclera. If one or more of these reactions occur, the drug should be discontinued. With antihistaminic therapy there have been reports of sedation varying from mild drowsiness to deep sleep, dizziness, lassitude, inability to concentrate, fatigue, incoordination, tinnitus, blurred vision, diplopia, euphoria, nervousness, insomnia, tremors, palpitation, hypotension, headache, chest tightness, urinary frequency, dysuria, tingling of the hands, dryness of the mouth, throat, and nose, gastrointestinal disturbances such as epigastric distress, anorexia, nausea, vomiting, constipation and diarrhea and very rarely, leukopenia and agranulocytosis. Adverse reactions reported with the use of sympathomimetic amines include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesicle sphincter spasm. PACKAGE INFORMATION: Trisulfaminic Tablets: Supplied in bottles of 100 tablets. CAUTION: Federal law prohibits dispensing without prescription.

DORSEY LABORATORIES • *a division of The Wander Company* • **LINCOLN, NEBRASKA**

STOP anxiety

but not your patient

For your anxious patients who must remain active, 'Stelazine' offers a specific, incisive antianxiety effect that can calm excessive anxiety without producing annoying dulling effects. On 'Stelazine' patients react more normally to stresses and at the same time remain alert enough to carry on their normal activities.

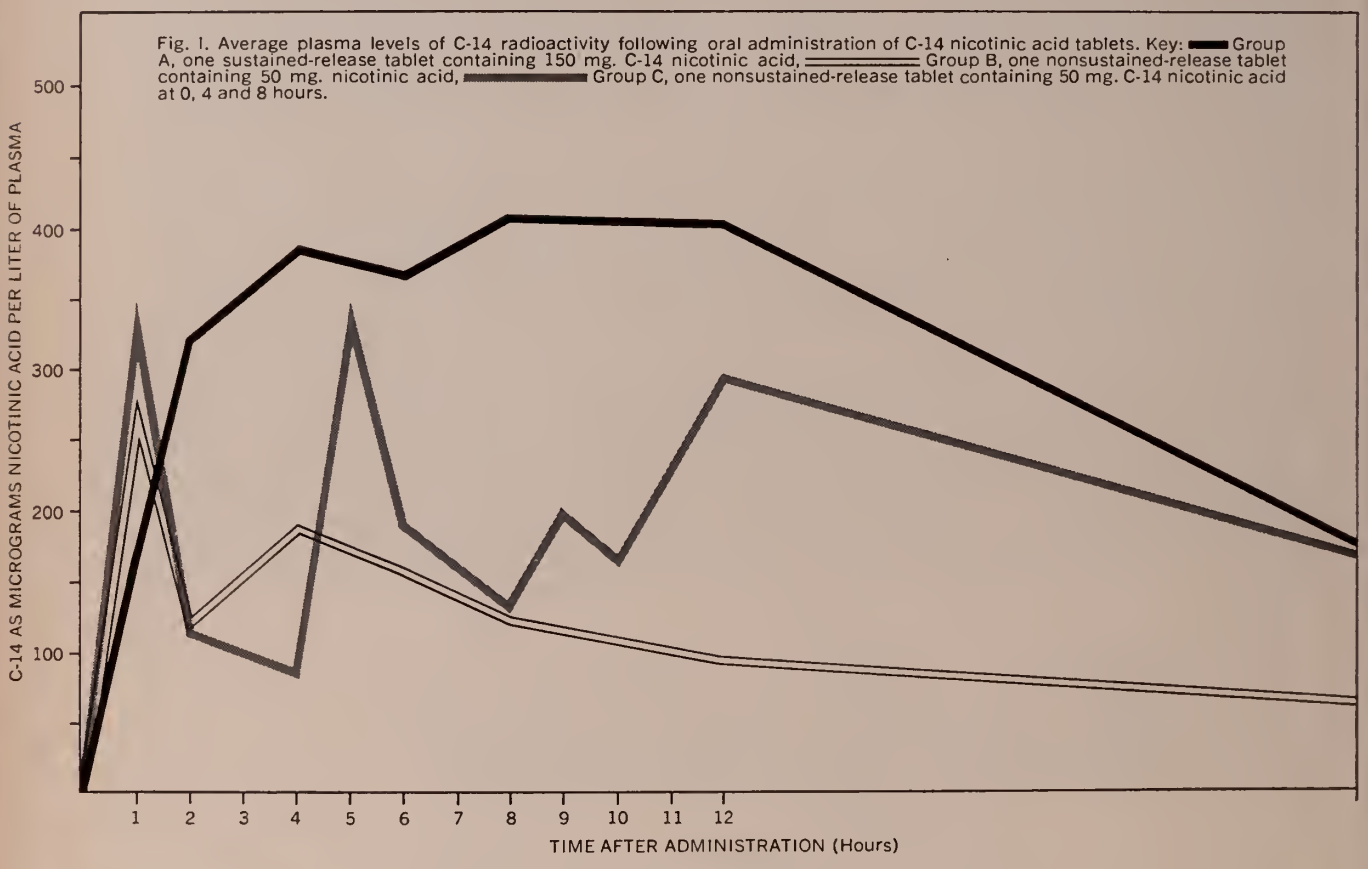
Stelazine®

brand of **trifluoperazine**

Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. The following is a brief precautionary statement. *Contraindications:* Comatose or greatly depressed states due to C.N.S. depressants and in cases of existing blood dyscrasias, bone marrow depression and liver damage. *Precautions:* Use with caution in angina patients and in patients with impaired cardiovascular systems. Antiemetic effect may mask symptoms of other disorders. An additive depressant effect is possible when used with other C.N.S. depressants. Prolonged administration of high doses may result in accumulative effects with severe C.N.S. or vasomotor symptoms. Use in pregnant patients only when necessary for the patient's welfare. *Side Effects:* Occasional cases of mild drowsiness, dizziness, mild skin reactions, dry mouth, insomnia and amenorrhea. Neuromuscular (extrapyramidal) reactions (motor restlessness, dystonias, pseudo-parkinsonism) may occur and, in rare instances, may persist. In addition, muscular weakness, anorexia, rash, lactation, hypotension, and blurred vision have been observed. Blood dyscrasias and cholestatic jaundice have been extremely rare. For a comprehensive presentation of 'Stelazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

Smith Kline & French Laboratories. Philadelphia

Sustained circulatory, respirator
and cerebral stimulation for the





(fewer absent doses by absent-minded patients)

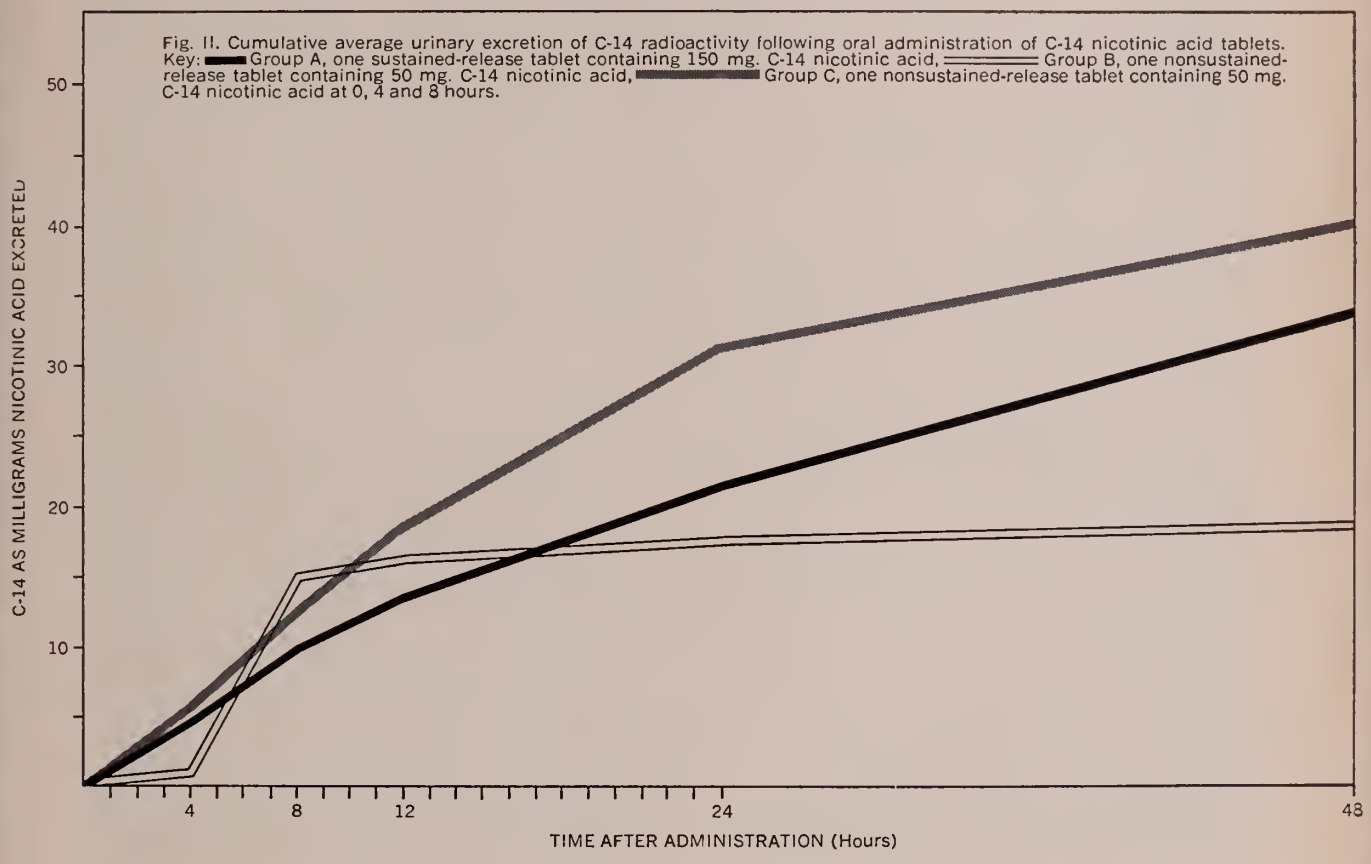
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

aged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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EDITORIALS

The Healing Art

Ours is surely the only medical society in the country with its 200-year history displayed within the covers of a book. (That's because no other medical society in America is 200 years old.) *The Healing Art* is a colorful, king-sized compendium of two centuries of our profession in general and our society in particular. It's a bright and proud volume that will excite you about your own professional heritage as a New Jersey doctor. At least that's what it will do if you have any sensitivity at all to matters like that. It's a colorful book, too, with pictures of old instruments, horse-drawn ambulances, important medical sites, and major characters in the New Jersey medical scene.

Here we learn how each county medical society developed; we learn, too, of the role of organized New Jersey medicine in our country's wars. There is an account of colonial medicine; a story, also, of plagues and pestilences and what we did about them; a commentary on industrial diseases in our heavily industrialized state; a candid discussion of medical economics through the two centuries; a view of the legislative, administrative, and medicolegal problems that have beset us. And, above all, there is a parade of New Jersey doctors — the great and the near-great; the solemn and the colorful; those of international fame and the less glamorous ones who faithfully served their localities — a cavalcade of our professional sires — the long and the short and the tall.

Dr. Rogers and Mrs. Sayre have caught the spirit of the two centuries and given us a book that will be easy to dip into from time to time, easy to read straight through page after page, easy to keep for reference. In the unfortunately ephemeral locale of the dust wrapper (front cover flap) is a tabulation of New Jersey medical "firsts" that makes such neophytes as New York or Massachusetts medicine seem like late-comers in medical progress.

On page 538 of this JOURNAL, we publish Dr. Berg's carefully restrained review. He is disappointed because some of his favorites were given too little space, or none at all. Probably every reader will be unhappy over the omission of a name that he reveres. However, even this fat book could not possibly house all the heroes in every member's medical Valhalla; so these disappointments are inevitable.

Every member of The Medical Society of New Jersey now owns this volume. It is one of the perquisites of membership. Many want extra copies for friends, relatives, patients, and for keeping in the waiting room. Such additional copies are yours at $10 each from the Executive Offices. That's only 3 cents a page: quite a bargain!

An old and proud family likes to emblazon its coat of arms on its mantel or over its door. *The Healing Art* is the insigne of our proud family: The Medical Society of New Jersey. It is an account of some wonderful men who handed us a great heritage. May we carry on in that tradition and be worthy of the service and dedication reflected in these pages!

The Return of the Plagues

Perhaps it is some natural or divine law (like the Bible story of the Flood, or the consequences of erecting the Tower of Babel), but every once in a while we are reminded that the diseases we lick don't always stay licked. We thought we had venereal disease conquered, but it is now making a come-back and it can't all be blamed on prostitutes. Even small-pox appears unpredictably from time to time in rather sophisticated communities. In Viet-Nam today, malaria kills more people than battle. By 1946, we thought we had *that* problem solved. Between DDT, which was to

destroy the anopheles, and a whole inventory of modern drugs which could cure the disease, it seemed as if this scourge would be substantially wiped out. It, too, is now returning to haunt us. The biochemists wage constant war against the bacteria, but like the battle between the makers of weapons and the makers of armor, the offense seems to provoke a defense. The current breed of bacteria often becomes resistant to the antibiotics that not so long ago felled them swiftly. Indeed, a potent chemotherapeutic or antibiotic agent against one generation of germs may be only a culture medium for the next one. We certainly have not solved the problem of air pollution, and that epidemic killer known as *accidents* shows no sign of recession. The Harrison Act, at first, cut down on the evil of opium-taking among the elite, and Prohibition briefly reduced the incidence of alcoholism. But both of these epidemics are now flourishing mightily. And tuberculosis now seems poised for a comeback.

Perhaps it is the penalty of *hubris*: the arrogant assumption that we have vanquished a scourge and that now we may relax our guard. Eternal vigilance remains the price we have to pay for suppressing the plagues — and keeping them that way.

Medication, Auto Accidents, And the M.D.'s Responsibility

Some years ago, the JAMA* pointed out that "Physicians administering drugs likely to produce impairment of sensory, mental, or physical functions have a clear responsibility to inform their patients about this, especially as it affects their ability to drive a motor vehicle." Most of the reputable manufacturers now include such caveats in their literature, and some degree of protection is afforded if the practitioner will simply pass that warning on to the patient. Advertisements in this and most other medical journals include such cautions as:

"Advise patients against possibly hazardous procedures until maintenance dosage is established" . . . "warn patients of possible combined effects with alcohol." Under "Precautions," one manufacturer advises, "Driving an automobile during the period of diazepam therapy is not recommended."

Obviously, when the manufacturer advises that patients be cautioned about driving while taking their drug, the patient should be given the benefit of the warning. With drugs such as the sedatives, tranquilizers, and antihistamines, patients should be told not to drive until they know that the drug is not affecting their alertness. Such side effects are usually dose-related, and reduction of the dose may permit continuance of medication in those who must drive. The effects of a given dose of any drug acting on the central nervous system vary greatly from one person to another. Even in the same person, a drug having no side effects at one time may have marked side effects another time.

Since warnings against driving are often ignored, the potential effects of drugs on drivers provide another reason for avoiding unnecessary prescription of drugs. Where sedatives or stimulants are genuinely needed, they may, by calming the patient or increasing alertness, prevent accidents. But, too frequently patients with transient, mild "nervousness" or depression are given prescriptions for sedatives, tranquilizers, or stimulants. Physicians should be aware of the driving as well as other hazards in brief and habitual use of many drugs, when they prescribe them and when they are asked to renew prescriptions.

The amphetamines have long been abused as stimulants and appetite depressants; their euphoric effects can impair judgment and cause some drivers to take excessive risks. While the physician cannot warn patients about potential driving hazards with *every* drug he prescribes, it is of interest that even antimicrobial drugs can sometimes have side

* JAMA: 169:1195-November 1959.

effects that impair driving ability. For example, nalidixic acid is offered with the warning that "in occasional instances" these side effects can occur: drowsiness, fatigue, and "reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity, and double vision)."

Sedatives, tranquilizers, narcotics, and antihistamines can cause drowsiness. These are present in most motion sickness and many cold remedies. Antidepressants can potentiate the central-nervous-system effects of alcohol, and figure in many of the accidents attributed to drunken driving. Drugs acting on the central nervous system can adversely affect alertness, motor coordination, skills, judgment, and other faculties essential for safe driving.

The wide range of drugs that can impair driving ability is sometimes overlooked by physicians, as is the fact that there are hazards to drivers in some of the most frequently prescribed drugs. Outstanding among these are the sedative or anti-anxiety drugs, such as phenobarbital and other barbiturates used for sedation, meprobamate, chlordiazepoxide, and diazepam. These drugs are prescribed for daytime use often without awareness that they frequently cause drowsiness.

A study of the effects of chlordiazepoxide on factors that might effect driving behavior (J. G. Miller, JAMA, 179:940, 1962) showed that when 20-mg doses were taken daily for one week (the dosage range recommended by the manuafcturer is 15 to 100 mg daily), ". . . judgment scores were poorer . . ." and ". . . subjects were more likely to increase their speed with a concomitant decrease in accuracy with this drug than with a placebo."

We doctors do not want Government to tell us what to prescribe and in what dosage. A sure way of bringing about this distasteful kind of bureaucratic intervention would be to dash off prescriptions for adolescents and adults (most of whom drive cars) without giving a warning about possible effects on alertness and driving judgement.

November is Life Month

"Life Month" is the annual enrollment campaign for the life insurance plan endorsed by The Medical Society of New Jersey. During November 1966, members under age 65 may apply (subject to company approval of the applications) for up to ten $10,000 units providing term insurance coverage of $100,000. Insured members may apply to increase their present coverage up to $100,000, subject to a physical examination. Members who have converted previously issued term policies may apply for as much as $100,000 new term insurance.

The amount of term insurance available under the program is $100,000. These policies include double indemnity for accidental death and waiver of premium benefit. More than 1700 of your fellow-members participate in the program, and have received benefits to beneficiaries in excess of $1,000,000 to date!

The valuable conversion privilege in the policy has been exercised by many policyholders to get permanent life insurance on a guaranteed issue basis, without physical examination or evidence of insurability.

Our Society's life insurance plan has lower premiums than comparable policies obtained individually, and may be retained even if you retire or move out of New Jersey.

The increased dividend scale is being continued and the dividends have been announced for all policies renewing prior to December 31, 1967. The dividend is $25 per $10,000 unit for those age 35 and under; $16 for those 36 through 40; $10 for 41 through 50; $6 for 50 through 60. This dividend scale will also apply to policies issued this year at their first annual renewal.

Members will receive complete information from the plan's administrator, E. & W. Blanksteen Agency, during "Life Month." Their address is 75 Montgomery Street, Jersey City 07302. They welcome your calls for information at DElaware 3-4340, area code 201; call collect, if you wish.

ORIGINAL ARTICLES

This is based on an address by Dr. Borsher at the annual meeting of the Medical-Surgical Plan Trustees on May 24, 1966 in honor of Dr. Sprague and Mr. Thompson.

Dr. Sprague's Role In The Early History Of MSP

Irving P. Borsher, M.D./Newark

On February 10, 1938, Dr. Edward W. Sprague delivered an address before the members of the Essex County Medical Society under the title, "A Plan for Adequate Medical Care for All." This was a plan based on the coordination of present resources, present principles of practice, and the American concept of government. This address was the intellectual foundation upon which The Medical Society of New Jersey built the Medical Service Administration of New Jersey, which in turn resulted in the organization of the Medical-Surgical Plan of New Jersey.

Doctor Sprague concluded with these words: "Let us steer clear of the recklessness in the extreme left and the smug, selfish complacency in the extreme right. In all this maelstrom about us, we as members of the profession must keep our thinking clear and courageous, be fully conscious of the needs about us, and be ready at all time to assume the burden of our ultimate responsibilities."

In September 1938, a special session of the House of Delegates of the American Medical Association endorsed the principle of voluntary medical expense insurance, if operated under the auspices or with the approval of the local or state medical societies. Shortly thereafter, Dr. William J. Carrington, then President of The Medical Society of New Jersey, acting upon the suggestion of Dr. Sprague, appointed a "Committee for the Study of Medical Cost Insurance" comprising Doctors Sprague, Spencer Snedecor, Thomas K. Lewis, Andrew F. McBride, E. Zeh Hawkes, Roy Wilkes, with Dr. Hilton Read as Chairman. They held their first meeting on October 16, 1938, with all members and a number of outside consultants in attendance, including Dr. Frederick Elliott of New York, who later helped to organize United Medical Service of New York. Each member of the committee was assigned to study a part of the field or to consult with one or more of the groups that would play a part in any program for medical care insurance. In November 1938, the members reported on their several assignments, and the committee submitted to President Carrington a number of recommendations.

"We believe," the committee declared, "that an experiment in the voluntary insurance field should be taken in New Jersey and that organized medicine should take the lead in developing this experiment." To that end, the committee suggested that it be relieved of further duties and that a new committee be appointed which should be specifically charged with the conduct of the experiment. Thus, Dr. Carrington appointed a new "Planning Committee" in January 1939, comprising Doctor Sprague as Chairman, and Doctors Elton W. Lance, George B. German, William H. Todd, and William C. Rucker. This committee was charged with determining the advisability and feasibility of developing a medical expense insurance plan for the State of New Jersey.

In its February 1939 report, this Planning Committee noted that it had "approached this problem with very meager records of

actual experience as a guide" and pointed out that "progress will need to be on an experimental basis, preferably of one year." The committee had been advised by the Commissioner of Banking and Insurance that the Medical Society as such should not institute an insurance plan, although the Society might initiate and organize the plan through a Board of Trustees designated by it. The committee noted the need of suitable legislation and said that its "proposal is to develop a system for independent self-help. The plan is to be an effort to assist the low income group to meet their catastrophic medical expenses by means of the insurance principle of the distribution of the costs over the community for a long period of time. Such a plan should preserve the individualism, competition, excellence, and rewards of private practice."

Among the basic principles which the committee felt should govern any such plan were:

1. That the plan be on a "non-profit basis with communal interests;"

2. That all fully licensed physicians in the State be eligible to participate;

3. That free choice of physician and free choice of patient be preserved;

4. That no membership fees be required of physicians;

5. That the policy must apply to the individual wherever he may be taken ill;

6. That payments should be limited to "house or hospital confining or otherwise disabling illness."

The Planning Committee concluded the report with a recommendation that it be discharged and that a "Founding Committee" be appointed by the President, of sufficient size to represent all parts of the state, empowered to expend money, to obtain necessary data, and to employ administrative help and legal counsel.

At the 173rd Annual Meeting of The Medical Society of New Jersey, in June 1939, Dr. Elton W. Lance, as Chairman of the "Founding Committee," reported on two months of intensive effort. On the basis of the committee's recommendations, a resolution was adopted that the Board of Trustees of the Society be authorized to appoint three members for the purpose of incorporating "The Medical Service Plan of New Jersey," and for the subsequent appointment, after one year of the corporation's existence, of a Board of Governors of the Plan. In the same action, The Medical Society of New Jersey voted to subsidize the new corporation to the extent of $5,000.

One of the Founding Committee's first accomplishments was the filing of the Certificate of Incorporation of the Medical Service Plan of New Jersey on July 13, 1939 under the existing laws governing non-profit corporations. The Trustees named in the certificate were Doctors Lance, Carrington, and Sprague. It was provided that "Doctor Norman Scott shall be the registered agent in charge." Doctor Scott was Executive Assistant of The Medical Society of New Jersey at the time and was known as the "Crusader" in connection with his work on the distribution of medical care in New Jersey.

At the start the committee realized that they were going into the insurance business and needed sound actuarial guidance. Dr. Sprague knew Mr. John S. Thompson, a nationally known actuary who at the time was Vice-President — and subsequently President — of the Mutual Benefit Life Insurance Company. Mr. Thompson consented to assist in the endeavor. He has been an invaluable guide as actuary and has always had a broad sympathetic understanding of the Plan's aims and problems. At his first meeting with the Committee, the title "The Medical Service Administration of New Jersey" was settled upon. In 1947 Mr. Thompson was made an honorary member of The Medical Society of New Jersey in recognition of his enormous contribution to the profession's endeavor in the field of voluntary medical care and insurance. From 1939 to 1942, the Committee (including Mr. Thompson) met in Trenton every 2nd, 3rd, or 4th Sunday, often took all day at it, stopping only for a sandwich at noon and paid their own expenses. In 1942 the meetings were transferred to Newark.

In the JOURNAL of The Medical Society of

New Jersey (February 1940), we find a note announcing that the current activity of the Board of Governors of the Medical Service Plan of New Jersey was "to formulate an Enabling Act governing medical service corporations, for submission to the present State Legislature. When the bill becomes a law the Plan will be put in operation." The same issue reviewed the program then under consideration. This was a comprehensive program of medical service, including home and office calls, surgery, obstetrics, x-ray, and laboratory services, anesthesia, consultation, plus an annual examination.

In April 1940 the Enabling Act passed the Senate by a vote of 16 to 1, and in May 1940 it passed the Assembly without a dissenting vote. Three months later, the Medical Service Administration announced that it then proposed to operate three plans; "one, the Medical Service Plan of New Jersey, a complete coverage plan; two, Medical and Surgical Service Plan for Hospitalized Patients, a 'catastrophic' illness plan to cover only the cost of illness requiring hospitalization; and three, the Farm Security Plan, to cover the cost of medical care of about 1,000 farm families in New Jersey."

On February 1, 1941, Medical Service Administration was publicly announced by The Medical Society of New Jersey and opened its offices in Trenton, with Norman Scott, M.D. as Medical Director and Mr. Joseph Hart as Executive Secretary. The Board of Governors comprised Dr. Lance as president; Mr. Thompson as secretary; Dr. Augustus S. Knight as treasurer; and Colonel Joseph Bigley, Dr. Edward W. Sprague, Mr. George W. Merck, Dr. William G. Herrman, and Dr. William J. Carrington as members of the Board.

In June 1941, the health insurance plans known as Number One and Number Two, were introduced to industry. A total of 800 organizations, each having one hundred or more employees, were interviewed. Plan Number One was the comprehensive program and Plan Number Two was the "Medical and Surgical Plan for Hospitalized Patients." Three months later Dr. Thomas K. Lewis, then President of The Medical Society of New Jersey, reporting on the development of the Medical Service Administration, stated, "very shortly, Plan Two will be in operation. This provides for payment for medical and surgical treatments of patients who are hospitalized. It is anticipated that policies of this type of service will be sold in conjunction with policies of the Hospital Service Plan of New Jersey." Early in 1942, a decision was reached by the Governors of Medical Service Administration to create a "separate corporation to confine its activity to the administration of a medical service prepaid insurance plan."

Dr. Sprague was a member of the Board of Trustees of the Hospital Service Plan of New Jersey. The following are the words of Mr. H. Theodore Sorg, then President of Hospital Service Plan: "Dr. Sprague was the motivating power that resulted in Medical-Surgical Plan of New Jersey. For two years, he pressed Hospital Service Plan of New Jersey to assume the task of enrolling subscribers for a medical-surgical prepayment plan. He eventually succeeded."

On March 22, 1942 the Board of Trustees of The Medical Society of New Jersey adopted a resolution approving "the incorporation of Medical-Surgical Plan of New Jersey as a non-profit corporation under the provision of Chapter One, Title 45, of the Revised Statutes, to establish, maintain and operate a non-profit medical and surgical service plan in conformity with the provisions of Chapter 45 — A, Title 17, of the Revised Statutes." At the same time, the Trustees approved a sales and administrative agreement between Medical-Surgical Plan of New Jersey and Hospital Service Plan of New Jersey "generally along the lines approved between Medical Service Administration of New Jersey and Hospital Service Plan of New Jersey." This resolution, adopted March 22, 1942, has been referred to as the "Magna Charta" of Medical-Surgical Plan of New Jersey. Three months later, the Plan enrolled its first subscribers and on July 1, 1942 it formally commenced operations.

And on the occasion of Dr. Sprague's retirement from the Board, the members of the Board of Trustees and the staff of the Plan gave a standing ovation to Dr. Sprague. He had attended 92 Executive Committee meetings and 342 meetings of the Board of the Plan, plus countless committee meetings and conferences. As Mr. Thompson was being accoladed as the Sage Advisor to the Plan, Dr. Sprague was saluted as Father of Medical-Surgical Plan of New Jersey.

(The Board of Trustees of The Medical Society of New Jersey here record their unanmious concurrence in this and direct that Dr. Borsher's tribute be published in the JOURNAL.)

306 Ridge Street

Carcinoma of the Endometrium — A Preventable Disease?

One hundred seventeen patients, ages 14 to 30, who were diagnosed as having either hyperplasia or carcinoma *in situ* of the endometrium, were studied between 1950 and 1962. Primary or secondary amenorrhea, oligomenorrhea, irregular bleeding, or infertility were presenting complaints. The data concerning histogenesis of endometrial hyperplasia suggest that prolonged episodes of annovulation and estrogen stimulation contribute to its development and that increased fertility will result from its correction and possibly serve as a propyhlactic measure against development of endometrial carcinoma. Prior to 1957, 22 patients were treated by wedge resection and 39 received hormonal treatment with progesterone, ethinyl testosterone and cortisone. Only 17 of these 61 patients ovulated; 11 subsequently became pregnant. Sixteen of this group were treated by hysterectomy later and three demonstrated invasive carcinoma of the endometrium. Since 1958, 16 of these 117 patients were treated by ovarian wedge resection, 24 with cyclic progestogens or cortisone, and six with constant progestogens. Six were treated with clomiphene citrate, ovulation eventually occurring in each of these six. Hysterectomy was performed on only one patient since 1957 and the pathology was questionable early invasive carcinoma of the endometrium.
R. W. Kistner, H. Gore, and A. T. Hertig: AM. J. Obst. and Gynec. 95:1011 (Aug. 1) 1966

Bacteriology of Large Burns Treated With Silver Nitrate

In an early treatment group of 26 patients, six of whom died with major thermal burns, the wounds were uniformly treated with thick gauze dressings continuously wet with 0.5% aqueous silver nitrate solution. Thirteen patients were first treated within 16 hours after the injury. Colonization of burns by pathogenic bacteria was significantly delayed. *Streptococcus pyogenes, Staphylococcus aureus,* and *Proteus* organisms were almost completely absent throughout convalescence. Bacteria of the *Klebsiella, Aerobacter,* and *Providencia* groups were the predominant inhabitants of these wounds and frequently — but not invariably — were the sole organisms isolated. *Pseudomonas* were grown early only from patients with very deep and extensive burns. They never predominated, except when death from sepsis approached. In a late treatment group of 13 patients, silver nitrate was not used until more than 48 hours had elapsed. When these patients were admitted, the burns were invariably heavily colonized with pathogenic bacteria. *Pseudomonas aeruginosa* and *S aureus* were practically always found before the silver nitrate was started. *S aureus* disappeared promptly. The initial mixed flora were progressively substituted for by *Pseudomonas* and *Klebsiella* and *Aerobacter;* these persisted throughout hospitalization.

L. Brenton *et al.*: Arch. Surg. 93:456, (Sept.) 1966

For peptic ulcer, the surgeon now has a wide repertoire of procedures. Dr. Baker here suggests a basis for selection.

Surgery For Peptic Ulcer*

Augustus L. Baker, Jr., M.D./Dover

The proportion of patients requiring surgery for peptic ulcer remains low, running between 10 and 15 per cent in most series.[1] The method of choice, however, is not as settled. Most of the impetus for new surgical procedures has come from the recurrences encountered, and, to a smaller degree, from other complications, such as diarrhea, "dumping syndrome," poor alimentation, and failure to maintain body weight.

The surgical treatment of peptic ulcers is considered to begin with the work of Bilroth and his colleagues in Vienna in 1880. In the earliest procedure, the lower stomach was removed and the remaining pouch anastomosed to the duodenum. This led to frequent recurrences. It was technically difficult, and there was a high incidence of postoperative problems due to the surgery itself. Subsequently, the operation (which persists today) became subtotal gastrectomy with anastomosis to the jejunum. This has been one of the most successful of procedures. The incidence of recurrences of the ulcer was reduced, but the loss of the storage factor led to loss of weight, diarrhea, and introduced the "dumping syndrome."

Much of the work has been directed to solving these problems. This has gradually produced a series of operations based on division of the vagus nerve as an integral part of the procedure.

* Read May 16, 1966 at Atlantic City before the Section on Gastroenterology of The Medical Society of New Jersey. This work is from the Department of Surgery of the Dover General Hospital.

Physiology

Peptic ulceration occurs only in areas subjected to acid gastric secretions. No one has been bold enough to say the acid alone is the cause. Probably the other ferments are necessary, too. However, it has been evident that neutralization of the acid present (or its elimination by surgery) is essential to the successful management of the basic problem and in the prevention of recurrent ulceration.

Other factors are immediately evident in the resistance of the stomach to active gastric juice. These include the mucus barrier, which is a continuous secretion of a tough layer very resistant to the digestive juices. Another factor is the rapid rate of mucosal regeneration if destruction should occur from any cause. Then there is cellular resistance as is realized in the observation that gastric mucosa is more resistant than esophageal mucosa, and in the fact that duodenal and jejunal mucosa are more resistant than esophageal mucosa. Also to be remembered is the dilution and neutralization of the gastric juice in the stomach by saliva, food and drink; and the neutralization of the acid chyme in the duodenum by the alkaline ferments there. Finally, we have to consider the mechanisms to prevent continuous secretion or hypersecretion of the gastric juices.

A review of the mechanisms of the secretory initiation and suppression of gastric digestive juices will lead us to the examination of the surgical procedures developed to treat peptic ulceration.[2] These mechanisms fall into three main phases: (1) cephalic, (2) antral, and (3) intestinal phase. The cephalic phase is mediated through the vagus nerves. The sight,

smell, and taste of food transmitted to the brain (or even the *thought* of food) sends impulses *via* the vagus nerves to the gastric cells. Thus secretion is initiated. It has also been shown that vagal stimulation can cause the release of the hormone gastrin from the antrum. The antral phase consists of the release of this hormone from the antrum as a response to the presence of food and muscular activity when the content is alkaline. Acidification of the antrum halts this stimulation. This is one of the mechanisms for stopping acid secretion within the stomach. Juice secreted in response to gastrin is high in acid content and low in pepsin. Knowledge of the intestinal phase has evolved from the finding that a small amount of gastric juice will flow from the stomach when food is introduced into the small intestine, although the stomach has been denervated and no food passes through it.

Animal experiments have clearly indicated that peptic ulceration will occur when there is hypersecretion of acid, such as occurs after prolonged and constant histamine stimulation of the stomach. This also happens when there is failure to neutralize secretion in a stomach with antrum detached, but constantly stimulated, as by being attached to the colon. Continuous alkalinization of the antrum will produce the same effect, and in animal preparations where gastrojejunostomy was also done, ulcers appeared on the jejunum. The reverse situation (failure of neutralization of acid duodenal content) is not as clear cut. Experimental surgery has indicated that in biliary tract obstruction or division, ulcers are more common, but the application of this to man has not been made.

The Clinical Problem

It has been well demonstrated that most patients with duodenal ulcer secrete more acid than the normal controls. Indeed, some of the values for the amount of acid secreted are extremely high. Those with gastric ulcer are lower, and with gastric cancer they may even be non-existent. That hypersecretion of acid is not the only factor that might be the cause of peptic ulceration is indicated in those patients who secrete at a normal rate, and the absence of ulcer in some patients with a high rate, plus the formation of gastric ulcer in low acid secretion states.

One or more underlying factors may be present in those patients with ulcer as the cause of the hypersecretion of acid. The increased stress of modern living has long been blamed with its resultant hypertonia of the vagus nerves. Stress, mediated also to the vagus *via* the adrenal cortexpituitary hormonal route, has been indicated in this additional way. Other endocrine systems are under extensive study since the description by Zollinger and Ellison[3] of severe ulceration resulting from islet cell tumors of the pancreas. Failure of the autoregulatory system (which occurs with stasis of food in the stomach) has been considered a factor. In this instance, if all of the antrum and pylorus are not removed in the usual subtotal gastrectomy a high incidence of ulcer recurrence is noted. These new ulcers usually heal after the pylorus is completely resected.

It has been shown[4] that patients with ulcer have a larger parietal cell mass capable of secretion of higher amounts of acid.

Of great interest in the formation of ulcer, particularly anastomotic ulcers, is the concept of mucosal boundaries of the stomach. In a carefully worked out paper[5] from the Jikei University School of Medicine (Tokyo, Japan) the relationship of these mucosal boundaries is clearly shown to be significant in the development of ulcers on the anastomoses, if the principles are violated. These principles are that ulcers develop adjacent to the boundaries of the stomach and opposite to the acid secreting area. To explain this further, gastric ulcers usually develop adjacent to the boundary of the fundic and pyloric gland areas and opposite to the area of acid secretion; i.e., in the fundic area. Duodenal ulcers occur on the boundary of the stomach and duodenum and opposite the acid secreting pyloric gland area; i.e., in the duodenum. They further show[5] that anastomotic ulcer will occur when the anastomosis is in the fundic area. Of fifteen cases of gastroenteros-

tomy studied, nine had anastomotic ulcer, and eight of these had the stoma in the fundic area. Only one had the stoma in the pyloric area. The remaining eight cases had no evident ulcer, and in only one of these was the anastomosis in the fundic area.

Unfortunately, this mucosal border can be identified only by histologic examination, and there are wide differences between the levels of these borders from individual to individual. This may well explain on a different basis some of our earlier failures with the procedures to be discussed than those usually expounded as the cause.

Surgical Applications

We can now see why some of the procedures were so rapidly discarded. Any operative technic that would continue to bathe the antrum with an alkaline mixture must cause an even greater acid response and further ulceration, either in the duodenum or on the gastrojejunal border. Likewise, if the stomach was prevented from emptying in a reasonable time (either because of obstruction of the outlet or because of lack of motility) the bulk stimulation of the antrum would again provoke increased acid secretion. In procedures designed to remove *all* of the acid-bearing portion of the stomach, any failure in the adequacy of the resection might lead to recurrences. Some of these doomed procedures include gastroenterostomy, pyloroplasty, gastroduodenostomy, pylorectomy, pyloric exclusion, 50 per cent gastric resection, and vagotomy alone.

Let us now examine the procedures that are in vogue today. Over the course of this century, the most widely-used operation has been the subtotal gastrectomy (in which 75 per cent of the stomach was removed and a gastroenterostomy done using a loop of jejunum). Results with this have stood the test of time in most clinics where the procedure was well carried out. The follow-up has been adequate and well-controlled in these series. Satisfactory results are reported in 90 per cent of patients. Operative mortality has been reduced to less than two per cent in the overall group and less than one per cent in the elective group. However, valid criticisms led to the search for a better procedure. Many deemed this a mutilating operation, which led to the "digestive cripple" who was either unable to maintain his weight, or suffered from the "dumping syndrome." Some said the postoperative mortality was too high, but it should be added parenthetically that this was in the group of patients operated for hemorrhage. Perhaps the greatest stimulus to a different approach was due to the proportion of anastomotic ulcers, since in most series the other problems were usually easily controlled medically, but most of the patients with anastomotic ulcers required further surgical intervention. Evidence has also shown that the fundic area is capable of an acid secretion of far lower pH than the pyloric area, and it leaves the patient with a highly acid remnant of stomach after all. To improve on these statistics, vagotomy was developed. Then it was soon evident that if this were to solve the problem, a drainage procedure would have to be combined with it. At first, a pyloroplasty was used. In theory, this should have been the ideal procedure, since the entire stomach is still present, the normal outflow tract is preserved, and the acid secretion has been eliminated. While the popularity of the procedure continued, the same 10 per cent of failures seemed to be encountered. It was then realized that the problem revolved around inadequate drainage. However, as we shall see, there is still a place for this procedure in the repertoire of the surgeon. Changing the method of drainage to gastroenterostomy did not reduce the incidence of failures. It was shown, however, that a high stomach site was a less desirable location for an anastomosis than one closer to the pylorus. This was noted by the Japanese authors.[5]

Let us now consider the latest of the procedures used and so far the most promising, although the follow-up period is still somewhat short. This consists of partial gastrectomy plus vagotomy. It was designed to combine the benefits of the antecedent procedures while avoiding their faults. In the resection, the antral phase of secretion is eliminated

and in the vagotomy, and the cephalic phase. The anastomosis is apt to have been constructed in the pyloric area. Preservation of a larger storage pouch seems to be of considerable assistance in maintaining nutrition.

Published results[6] reveal that the recurrence rate is showing a marked decrease to below one per cent in most series. Even these are traceable to incomplete vagotomy and pancreatic adenomata of the Zollinger-Ellison type.

A word about selective vagotomy should be inserted. Since the vagus also innervates other organs of digestion, there is the obvious inference that its division just below the diaphragm (the classic vagus section) would seriously affect the function of the gall bladder, pancreas, and small intestine. Results of animal and clinical studies vary somewhat as to the significance of this denervation, but the procedure itself has had some strenuous criticism. Most operators blame their poor results on inadequate vagotomy. But the proponents of selective vagotomy state that they get a more complete denervation of the stomach by this painstaking dissection. There seems, therefore, to be a high incidence of proving what was the original thesis of the reporting groups, leaving the rest of us to draw our own conclusions.

Summary

Presented is a concise review of the progress of the surgical treatment of peptic ulcer. Three operations are now in general use. They are the "adequate" subtotal gastrectomy, vagotomy with a drainage procedure, and partial gastrectomy with vagotomy. The selection of the treatment of choice among these three general methods, to fit the manner in which the patient presents for surgical care, has been left to another paper.

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The revenue that comes from our advertisers is not only appreciated but also makes possible the publication of this state journal at a reasonable cost to each member of M.S.M.S. But of very great importance and value is the basic information that can be found in the pages they provide.

Michigan Medicine, September, 1966

Open thoracotomy with control of bleeding is often a lifesaving procedure in this (by-no-means-rare) thoracic catastrophe.

Spontaneous Hemopneumothorax

Franklyn P. Gerard, M.D./Newark
Adrian M. Sabety, M.D./East Orange

Among the spontaneous catastrophes of the chest, probably the most ignored problem is spontaneous hemopneumothorax. Review of publications on thoracic trauma and treatises on chest emergencies leads one to believe that this is so rare that it is hardly worth mentioning. In the past few months we have had two occasions to treat this specific problem. Each case had its own particular lesson in management. Since the emergency is such that if it is not recognized mortality can result, we feel it imperative that attention be called to this problem.

Case One

A 21-year-old man was sent to St. James Hospital in Newark by his family physician who had made a diagnosis of spontaneous pneumothorax. The patient had been stricken with sudden sharp pain in the left chest followed by shortness of breath and fainting. Seen in the emergency room, he was in moderate distress. Blood pressure was 80/60; pulse was weak and thready. He had respiratory distress and moderate cyanosis of lips and nail bed. An upright chest x-ray (Figure 1) taken immediately on admission to the emergency room revealed a total collapse of the lung, with no apparent shift of the mediastinum and some blunting of the costophrenic angle.

An intravenous of 5 per cent glucose in water was immediately started. The patient was promptly typed and cross-matched. A tube thoracotomy was carried out in the emergency room with an egress of air under considerable pressure. Following the thoracotomy and intravenous fluids, his condition appeared to stabilize and he was transferred to the Intensive Care Unit. Two hours later he was in shock, and at this point it was further noted that fresh blood was draining from the thoracotomy tube which had been placed in the anterior-axillary line in the third interspace. Within thirty minutes, some 800 cubic centimeters of bright red blood was drained from the chest tube without suctioning. The shock persisted. Immediate transfusions were carried out and the operating room prepared. The patient was taken to the operating room.



Figure 1. Upright chest x-ray revealing complete collapse of the left lung, shift of mediastinum indicating tension pneumothorax, and air fluid level indicating hydropneumothorax.

The left chest was entered and a large amount of clot and free blood evacuated. At the apex of the lung a bleb was noted with some bleeding. At the apex of the pleural cavity, a small arterial pumper was readily noted and cauterized. After complete evacuation of the chest cavity, the lung was expanded, the chest was closed, and the patient went on to an uneventful recovery with no further bleeding.

Case Two

A 19-year-old male was admitted to East Orange General Hospital by his family physician after complaining of sudden pain in his right chest followed by shortness of breath and two episodes of fainting. X-rays of the chest on admission to the hospital revealed a 50 per cent hydropneumothorax (Figure 2).

The attending physician carried out a thoracentesis and withdrew free bright red blood. A diagnosis of spontaneous hemopneumothorax was made and the operating room was prepared. While waiting for the cross-matching of blood, the patient developed a drop in blood pressure, increased pulse rate, and seemed in shock. He was immediately transfused and taken to the operating room. The right chest cavity was opened and free blood was readily evacuated. A large bleb in the apex of the lung was noted and removed. Search for a bleeding vessel in the apex of the hemithorax corresponding to the area of the bleb failed to reveal a specific source of the bleeding. There was extraordinary oozing from the chest wound. The lung was expanded, the chest cavity was closed, and the patient was transferred to the Intensive Care Unit. Later that day it was noted that his blood pressure was dropping slowly. He was given blood, but his general condition appeared to deteriorate rapidly. Over 1200 cubic centi-



Figure 2. Upright chest x-ray revealing hydropneumothorax 24 hours following onset of right chest pain accompanied by syncope.

meters of fresh blood were drained from the hemithorax within eight hours. In view of the non-specific nature of the bleeding site, a work-up for blood dyscrasia was immediately carried out. This disclosed a prothrombin time in excess of 90 seconds. Fresh blood and fresh frozen plasma were immediately administered. The patient was again returned to the operating room after a chest x-ray revealed the entire hemithorax obscured by fluid. At surgery, a considerable amount of clotted and free blood was removed from the chest cavity. The lung was again expanded. Before the second thoracotomy was carried out, an adequate period of time had been allowed to pass for the plasma to take effect. Following the second procedure, the patient proceeded to make an uneventful recovery. Prothrombin time by next morning was within normal limits. Six weeks following this episode, the patient was re-evaluated from a hematological standpoint and the only abnormality noted was that of a marked abnormality of the Factor X.

Comment

The treating physician can quickly become suspicious of an "unusual" case of spontaneous pneumothorax when the patient either faints (as in Case Two) or goes into shock (as in Case One). It is unusual for a case of spontanous pneumothorax to deteriorate to this extent. Therefore, with this added diagnostic point, the chest x-ray will help immeasurably. Fluid in spontaneous pneumothorax of short duration will usually indicate a hemopneumothorax (see the figures). Naturally, an untreated pneumothorax will develop some fluid in the chest cavity after a number of days, but this is not usually found within the first 24 hours of the apparent onset of the collapse. These two points — (1) the history of fainting or shock and (2) x-ray evidence of hydropneumothorax — are most significant in the recognition and rapid management of spontaneous hemopneumothorax. The treatment is open thoracotomy and control of the bleeding. The vessel in Case One was extremely small. In a matter of four hours this young patient had lost some two quarts of blood from this "small" blood vessel. Attempting to manage this problem merely by tube thoracotomy and blood replacement, we feel, would lead only to a prolonged hospitalization and probably would result in the need for decortication due to the extensive hemorrhage. Case Two presents an interesting complicating factor in the management of this problem. The tendency to ooze was readily noted at surgery and the inability to find the specific bleeding point should have immediately alerted the operating surgeon to the possibility of blood dyscrasia. If blood studies had been carried out at the time of the first thoracotomy, it might have been possible to proceed immediately with the fresh plasma and thus prevent further hemorrhage which resulted in the second thoracotomy. It might be pointed out that the past history revealed the patient had had an appendectomy four years prior with no apparent difficulty.

Summary and Conclusion

Two cases of spontaneous hemopneumothorax

— a thoracic catastrophe which is infrequently seen, and, for the most part, ignored — have been presented. Diagnosis can best be made by the history of fainting or shock-like state accompanying spontaneous pneumothorax and the x-ray which shows a hydropneumothorax. The treatment is open thoracotomy with control of bleeding. We would further recommend a brief hematological survey such as bleeding, clotting time, prothrombin time, and clot-retraction time.

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377 Roseville Avenue (Dr. Gerard)

Ethical Telephone Listings

The AMA has recently published *Guidelines for Telephone Directory Listings.* In most matters, and in doubtful cases, "the county medical society, in the last analysis, must ascertain community needs, and through a well thought-out program, serve those needs." The AMA, however, does issue broad guidelines and adds that "it is incumbent on the county medical society to implement these guides for the local medical community."

On the approved side of the ledger, the AMA lists the "simple statement: practice limited to—". However, there are several caveats to this "simple statement." First, the practice must indeed be limited to the speciality and not merely reflect a special interest within the field of general practice. Second, it must be a specialty recognized by the AMA. A listing which indicates that the doctor specializes in making fat people thin, for instance, would not meet this definition. Third, the doctor must not specialize in more than two fields at once. Fourth, display notices, information set in boxes and boldface type (if all other doctors are listed in light face) are all frowned on. Finally, the doctor should not be listed in the yellow pages of an area where he neither lives nor has a hospital affiliation nor an office. The AMA prefers the name followed by M.D. It doesn't like the abbreviation "Phys." after a name or "Dr." before a name. In any year in the USA, more than two-thirds of all doctors' degrees are to people other than M.D.'s. (The Ph.D.'s win the blue ribbon, but in the past year the doctorate degree field has run the gamut from agronomy, architecture, and animal husbandry to social work, Spanish, and textiles.)

The AMA encourages county medical societies to list their offices, phone numbers, and services to patients — like emergency call referrals. For individual doctors, the AMA no longer objects to listing office hours (or "by appointment") but does frown on display advertising or listing of fees or special degrees other than M.D. Also objectionable is a listing in any directory that is not open on like conditions to all licensed physicians in the community.

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The companies and places which advertise in this JOURNAL merit your support. The fact that their advertisements are here is assurance of their reputability. By placing these notices in these pages, they assist your JOURNAL and your Society.

This is the third of a series of articles on workmen's compensation and industrial rehabilitation in our state.

Rehabilitation of The Disabled Worker*

Administrative Problems

Jarvis Smith, M.D./Trenton

Workmen's Compensation has been plagued with administrative problems ever since its inception in 1911. When it was first passed, the statute created no administrative machinery. Rates and schedules of compensation benefits were set forth, but in the event of controversy the only appeal was to the Court of Common Pleas (now the County Court). The Legislation did provide for an Employer's Liability Commission to observe the operations of the act and to report yearly to the Legislature. In its first report issued in 1912, the Commission was optomistic; but by the next year it was recognized that there were administrative deficiencies in the law. Workers had no idea of where to apply for information about the law and no place to turn if the settlements which were proffered were not adequate.

Makeshift remedies were devised by the Legislature in the form of a Workmen's Compensation Aid Bureau in 1916; but it was not until 1918 that a Workmen's Compensation Bureau was created in the Department of Labor with the Commissioner of Labor as chairman. Today, the decision of the judge of the Division of Workmen's Compensation may be appealed to the courts where there is a trial, including the re-argument and re-weighing of the evidence.

In common with the statutes in so many other jurisdictions, the philosophy is that the worker and the employer should come to some meeting of minds concerning the amount of compensation benefits that are due. And, failing that, tribunals are provided to adjudicate disputes.

In the post World War II period when the Direct Settlement Review Program was instituted, close collaboration between the Rehabilitation Commission and the Workmen's Compensation Bureau was not the result of any legislative enactment but of administrative changes within the old legislative framework. These efforts to induce a note of possible administration in the law are a tribute to the devoted people who have been assigned administrative responsibilities and who recognize the deficiencies of the statute with which they are called upon to work.

The Institute's panel on administration recognized the extreme breadth of the area and confined itself only to a few of the many problems that need constant discussion. It recognized that the real challenge was to work within the existing framework to accomplish the desired goal of bringing rehabilitation to those workers who can profit by it.

Providing Information for the Parties

Much of the present responsibility for the administration of the individual case rests with the employer or the insurance carrier. This responsibility may be effectively discharged by the large insurance carrier which has assumed the burden of providing adequate medical care and rehabilitation services. However,

* An abstract by Jarvis M. Smith, M.D. — Medical Director, New Jersey Rehabilitation Commission—from the original monograph by Monroe Berkowitz, Ph.D.

small carriers may be represented by only a few representatives who have neither the time nor the knowledge to purchase the best in medical care and services. In such situations, much could be done by providing carriers with information about the services available within the State including the services of the Rehabilitation Commission.

Comparable information must be provided labor unions and employees. Employees cannot request the rehabilitation services to which they may be entitled if they do not know what is available. Both employees and labor officials should be made familiar with what can be accomplished through rehabilitation so that effective programs can be undertaken when the need arises. The panel endorsed the present efforts that are being made in informing labor union officials and shop stewards — an outgrowth of the program on rehabilitation conducted in cooperation with the Institute of Management and Labor Relations, Rutgers University. The more that can be done to make labor rehabilitation conscious, the less large will loom the problem of placement of disabled people.

Responsibilities of the Division

The responsibilities of the carrier are large, and the basic financial responsibilities for the vocational rehabilitation of workers with employment-connected disabilities are properly that of the employer. This does not lessen the administrative responsibilities of the workmen's Compensation Division. It is vital that the Division have available to it certain basic information if these responsibilities are to be carried out. Periodic reports filed by the parties should contain information about medical and vocational rehabilitation services which are indicated and whether or not these services are being offered. Sufficient medical information should be provided to allow personnel of the Workmen's Compensation Division to evaluate whether appropriate rehabilitation efforts are being made by the carrier. This is especially necessary in cases where the carrier has a record of inadequate supervision of cases. The Division should be responsible for assessing the performance of the carriers in this respect.

The Institute's panel endorses all methods which have been used to bring about a closer relationship between the Workmen's Compensation Division and Rehabilitation Commission. The Rehabilitation Section in the Workmen's Compensation Division was started in 1956. The Coordinator who supervises this Section receives "First Report of Accident" forms after selection is made from a close screening of those who could possibly benefit from rehabilitation. The work of the Rehabilitation Section had been financed largely from grants provided by the Vocational Rehabilitation Administration until 1964. In that year the Rehabilitation Section became an established section operating with a section director and three rehabilitation counselors. The time has now come to establish a fully staffed Rehabilitation Section in the Workmen's Compensation Division financed by State funds. Such a section should include competent medical personnel to supervise the medical aspects of the work. An adequately staffed section with power to review cases could bring about as dramatic results in the area of rehabilitation as the Direct Settlement Review Program has brought about in that area.

Real progress in administration cannot be made in the absence of essential information. All efforts should be made toward compiling statistics on the types of cases which benefit by rehabilitation, the times when they should be referred, and the long-term results of their referral. Only on the basis of more adequate information can progress be made.

A New Spirit of Cooperation

With adequate staffing and information must come renewed determination to bring rehabilitation to all who can benefit from it. Workers must be made aware that Workmen's Compensation involves something more than cash benefits. Lawyers must be made aware of the potential of rehabilitation and the fact that this will benefit and not harm their

clients. Specifically, insurance carriers must be made aware that one way to reduce medical costs is to provide the best possible medical care promptly, and generally they must recognize all the opportunities that are possible in the area of rehabilitation. Above all, the physicians must become aware of the potentialities of rehabilitation procedures beyond the acute medical phase and of the necessity of prompt reporting and referral. Close cooperation can work in New Jersey if all bend their efforts to the common good and recognize the potential involved in the prompt and adequate provision of rehabilitation services to the injured worker.

Recommendations

1. The Rehabilitation Section within the Division of Workmen's Compensation should be expanded and strengthened.

2. The Rehabilitation Section within the Division of Workmen's Compensation should have available to it a full-time medical staff to assist in making evaluations and referrals.

3. The Rehabilitation Section within the Division of Workmen's Compensation should be financed by State funds.

4. Responsibility for vocational rehabilitation to workers with employment-connected injuries is largely that of the employer. Public funds of the rehabilitation agency should be looked upon as supplementary in the provision of these services, particularly when the worker is additionally handicapped by non-industrial or pre-existing disabilities.

5. It is the proper function of the Division of Workmen's Compensation to see to it that the workers receive all the benefits to which they are entitled under the law, including medical care and rehabilitation services. These are the responsibility of the employer and his insurance carrier.

6. Reporting forms presently required by the Division should include information about the medical and rehabilitation services indicated and whether they are now being provided. Sufficient information should be provided on these forms for adequate screening by the Rehabilitation Section.

7. It is necessary for the Division of Workmen's Compensation to assume responsibility for disseminating information about the rehabilitation of workers.

8. Labor unions should be made aware of the potential involved in the rehabilitation of workers. The Institute's panel endorsed the educational efforts that have been made in cooperation with the Institute of Management and Labor Relations at Rutgers University.

9. Educational programs should be further developed to bring to union members and their officers the need for solutions to the problem of rigid seniority provisions which interfere with the employment of "qualified" handicapped workers.

10. The cooperation of the local medical societies should be enlisted in informing the physician about the potential of physical and vocational rehabilitation and the vital necessity for prompt reporting and referral of disabled patients.

11. It should be the responsibility of the Division of Workmen's Compensation to compile adequate statistical information for better evaluation of potential in the referral of injured workmen.

If this article, or any of the series, stimulates questions, they should be sent to Jarvis M. Smith, M.D., Medical Director, New Jersey Rehabilitation Commission, John Fitch Plaza, Trenton, New Jersey 08625. At the conclusion of the series, Dr. Smith will answer such questions in THE JOURNAL.

John Fitch Plaza

In the bad old days, when there was little the doctor could do — except stand by — he was adored. What has happened to that image? Here is one explanation.

Honor A Physician?

Some Thoughts Upon The Doctor-Patient Relationship

Humphry Osmond, M.D.*/Princeton

Honour a physician with the honour due unto him for the uses which ye may have of him:
For the Lord hath created him.
For of the most High cometh healing,
And he shall receive honour of the king.
The skill of the physician shall lift up his head:
And in the sight of great men he shall be in admiration.
The Lord hath created medicine out of the earth;
And he that is wise will not abhor them.
Was not the water made sweet with wood,
That the virtue thereof might be known?
And he hath given men skill,
That he might be honoured in his marvellous works.
With such doth he heal men,
And taketh away their pains.
Of such doth the apothecary make a confection;
And of his works there is no end;
And from him is peace over all the earth.
My son, in thy sickness be not negligent:
But pray unto the Lord, and he will make thee whole.
Leave off from sin, and order thine hands aright,
And cleanse thy heart from all wickedness.
Give a sweet savour, and a memorial of fine flour;
And make a fat offering, as not being.
Then give place to the physician,
For the Lord hath created him:
Let him not go from thee,
For thou hast need of him.
There is a time when in their hands there is good success.
For they shall also pray unto the Lord, that he would prosper that,
Which they give for cast and remedy to prolong life.
He that sinneth before his Maker,
Let him fall into the hand of the physician.
From Ecclesiasticus.

This outline of the relationship between doctor and patient comes from the wisdom of Jesus, the son of Sirach, better known as the Book of Ecclesiasticus. Written in the second century B.C., it is remarkably apt and fresh today after two millennia. It is an index of how stable this relationship has been, and this suggests that if changes have begun to occur they are likely to be peculiarly disconcerting to everyone involved, for we have a very clear picture in our hearts — if not in our heads — of just how doctors and patients ought to conduct themselves. During the last five thousand years, at least two historical physicians have become gods: Imhotep and Aesculapius. Others like William Palmer have been executed for murder; or like the renegade doctors tried at Nuremberg, for genocide. Starting with St. Luke, medicine has had its share of saints; and as the melancholy records of the General Medical Council show, it continues to have its sinners, too. Many of the gravest problems facing our species today are derived directly or indirectly from the astonishing success of medicine and its spawning of daughter sciences. In spite of this, medical men and their patients, too, pay little attention to the extraordinary influence which this ancient art or craft exerts upon our affairs. Indeed, many consider (if they think about it at all) that the relationship between doctor and patient, medicine and society, is an academic matter of little importance.

The author of Ecclesiasticus was neither vague nor unconcerned. The physician is to be honored because of the "uses ye may have of him"; that is, his social function: what he does. His social function is healing, which comes "of the most high." The physician shall receive "honor of the king," because "the skill of the physician shall lift up his head." This implies that the physician, even though previously lowly, shall be given high status.

* Read by invitation before the Section on Psychiatry, Annual Meeting of The Medical Society of New Jersey, in Atlantic City, May 16, 1966. Dr. Osmond is Director, Bureau of Research in Neurology and Psychiatry, New Jersey Division of Mental Health and Hospitals, New Jersey Neuro-Psychiatric Institute, Princeton.

Yet, that great men shall admire rather than envy him suggests that it is skill deriving from divine knowledge rather than position in the social hierarchy, which results in the physician being honored. A physician is perceived as being good, because he is an instrument by which divine compassion expresses itself. The sick person, having made his peace with God, must give place to the physician whose skill is but another aspect of the same divine spirit. But those last two lines—the "punch lines"—are disquieting. It is unfortunate to fall into the hands of even the most admired and honored physician whom the Lord has created. Indeed, one is left wondering uneasily whether the physician is part of a divine attempt to reduce human suffering or another rod for the backs of the naughty. This ambiguity is not accidental, but reflects an uncertainty about illness deeply rooted in man's nature and history.

Medicine is a very old art or craft. Not only did it precede our present sciences, but it has been the mother of many of them from astronomy to biophysics. Physics, chemistry, anatomy, physiology, pharmacology, biochemistry, and genetics are only a few of its daughter sciences. Yet, in spite of this, medical men are, for the most part, practical artists or craftsmen rather than scientists. Their customs and behavior resemble those of guildsmen or craft unionists rather than those of scientists or technicians. Young men learn the art of clinical medicine from a prolonged association with elder men who have themselves acquired their knowledge of the values and customs of medicine from their seniors. In spite of medicine's extraordinary fecundity as a mother of sciences, it was very slow to make use of one of science's most formidable tools: exact measurement. This came into medicine little more than a century ago in the face of ridicule and long-drawn-out opposition by slothfulness, for suitable instruments had been available for at least one hundred years.

Measuring the pulse with a stop watch, taking the temperature with a thermometer rather than estimating it with the palm of the hand, listening to the heart and lungs, testing the urine, even examining the patient's body with both hand and eye have all been in their time looked upon as absurd, revolutionary, or even dangerous innovations. What we now consider ordinary cleanliness was resented by able and intelligent doctors in the 1850s. It is characteristic of an art or craft that skill is believed to reside in those who practice it rather than in any abstract body of knowledge or concepts. This way of looking at knowledge is useful and sensible, but it has some disadvantages, for those who have once acquired status in the practical art of healing rarely feel strongly impelled to seek or encourage change. Indeed, they have usually found reasons why change should be discouraged. They themselves, having already become skilled craftsmen versed in the mystery of medicine, find it unreasonable for others to do anything better than they can do it themselves. It is easy enough for us to mock such conservatism; but for most of the millennia during which medicine has been practiced, conservatism has usually been in the best interests of patients. New skills were acquired slowly. In the absence of well-organized medical schools and printed textbooks the transmission of information from generation to generation was very uncertain. There were then no means of testing innovations except on patients. Much of what is new (as we rediscover painfully and repeatedly) is also bad, or at least no better than that which we already have. The great Hippocratic aphorism finds an echo in the heart of every clinician, especially as he gets older: "Life is short and Art is long; the crisis is fleeting, experiment risky, and decision difficult." The good physician was old, wise, cautious, and compassionate. He had seen much illness and profited by many mistakes, his own and those of others. His art, like that of the politician, was the art of the possible. Above all, he knew when not to interefer with the course of nature. The relationship between doctor and patient is an ancient one, rooted in societies and times quite unlike our own. It had changed very little for centuries — millennia even — until perhaps fifty years ago or so, since when it has begun to alter quickly and seemingly unpredictably. These changes have been bewildering and un-

comfortable for both doctors and patients.

We can all benefit by trying to understand what has already occurred, what may now be taking place, and so make some intelligent guesses about what may happen in the future. It seems that all human societies have words with which to describe injury and disease. Ailing people may be seen as hindrances or encumbrances to be disposed of by execution or even cannibalism; they may be driven out, abandoned, or treated with more or less consideration. Nearly all languages distinguish the "sick" as a special kind of person and have particular words for those who attend them and have expert knowledge of illness. This specialization of knowledge about injury and disease—whether the intention be to dispose of those afflicted, prevent them from harming other people, or to restore them to health and social functioning—is very old then. Great skill has long been acquired in these matters. Neolithic man, for instance, was able to trephine with a flint instrument. The bone edge shows signs of healing which indicate that patients survived these early surgical adventures, at least for some time. This also shows that the holes were not bored to suck out the brains for food, as some cannibals have done until recently. We can safely say that for at least five thousand years, men of diverse cultures in many parts of the world have considered that the art of healing was a branch of human endeavor requiring special application and aptitude. As the writer of Ecclesiasticus states, those who excel in this art have received recognition and admiration.

While granting the physician (and later the surgeon) a privileged position in society due to the benefits to be derived from his skill and wisdom, every society has demanded, nevertheless, that he should exercise that skill in a manner acceptable to it.

Those who treat the sick have always been guided by certain notions or preconceptions, which have become, in course of time, ideas about the origin and nature of disease. Sickness has been seen as bewitchment by an enemy, possession by a devil or evil spirit, the result of some breach of social or religious custom, due to a malign conjunction of the stars, punishment or testing by a god, or vaguely as just bad luck. But since about 500 B.C., the time of Hippocrates of Cos, there has been a tendency, especially in Europe, to ascribe illness to "natural causes." This bold and revolutionary move was not necessarily any more convincing at first than the current notions of witchcraft, astrologic influences, demonic possession, or divine punishment which we now find bizarre. It was one of the many examples of that extraordinary good taste and sense of fitness which predisposed the Greeks toward the idea of a "natural order." They believed that such a natural order could be explored, used, and to some extent understood by those who were prepared to make sufficient sustained effort. For centuries this Greek good taste was no more self-evident than those superstitions which we now find so strange or even contemptible. Their rationalism was in itself an astonishing act of faith which has become so much part of our lives that we easily fail to recognize its grandeur, because we are so accustomed to it. When urban societies enlarged, medical men emerged as those who had the right and duty to treat the sick, to direct those who looked after them, and to devise measures for preserving public health and warding off illness. These rights and duties derived from a belief based upon traditional experience that certain people possessed special competence in these matters. The way in which particular medical men exercised this competence depended upon the underlying assumptions of the culture to which they happened to belong. Many 17th century physicians were practicing astrologers who cast horoscopes as a regular part of their diagnostic and treatment schemes without arousing unfavorable comment. Astrology was just as respectable as, say, radiology or biochemistry is today, and possibly more widely accepted than psychoanalysis.

Until very recently, the cause of nearly all illness was obscure. The differing opinions of experts were rarely subjected to experiment. From the patient's point of view some

things were clear enough: illnesses were usually painful, expensive, long continued, and often fatal. All through their short lives people were confronted by serious illnesses in their homes and in those of their neighbors. In Halifax, Nova Scotia, I copied this from a single gravestone recently,

Edward, son of Edward Duckett, 8th November 1839, 3 years and 10 months.
Edward James, 18th February 1840, four months.
Charlotte Maria, 10th May 1841, 4 years and 4 months.

Our forebears lived in the immediate presence of death far more than we do today. Few grew up without losing parents, brothers, and sisters. People did not die carefully drugged and well-hydrated in hygienic hospitals attended by efficient nurses. They died painfully and often very slowly, nursed by weary and frightened amateurs, in homes disorganized by their dying. In *The Death of Ivan Ilytch,* Tolstoy lets one recapture the horror of it. During those repeated agonies, the family doctor sustained hope. When there could be no more hope, he inspired the feeling that everything that could be done had been done. And this was true.

Long illnesses, much pain, great disruption reverberating through the distressed family, the imminence of death for weeks or even months, convalescence often greatly prolonged by inadequate or improper diet and punctuated by inexplicable relapses resulted in patients who, if they survived, knew their doctors well and were likely to heed their opinions. After such an ordeal, patients were prone to believe that they owed their lives to their particular doctor's skill, judgment and devotion, and that he had turned the scales in their favor. There was no need to foster such beliefs for they grew quite naturally. Patients took their doctors' advice, however odd or even repugnant it might be, because they had personal experiences which seemed to show that those who disregarded the doctors' orders were more likely to die. As Ecclesiasticus put it,

Then give place to the physician for the Lord hath created him;
Let him not go from thee
For thou hast need of him.

Patients and their families knew their doctors from their presence during repeated, long continued, agonizing, and often humiliating illnesses. At a time when medicine could do little to influence the course of most illnesses, doctors were heeded at least as carefully as they are today.

For the whole of the last century—and especially during the last 25 years—medicine has been changing swifty and dramatically, illnesses which once lasted for months or years are now treated in days or weeks. Illnesses which were once fatal or crippling are now cured so quickly that they seem almost trivial. I had a friend who developed cerebral malaria after returning from Africa recently. One Sunday night he was admitted to a London hospital in coma. He remembers very little of that week until about Wednesday. By Friday, he was talking of leaving the hospital; and indeed he was discharged on Monday morning after spending little more than seven days there. He had completely recovered from an illness which has often been fatal in the past. Although he is intelligent and knowledgeable, he does not seem to grasp fully that his life was saved with unobtrusive efficiency. The brevity of his illness, which springs from that efficiency, has reduced his feelings about it. This has been a brush with death, a mere skirmish, not a long-drawn-out campaign in which he could gradually recognize and slowly accept his complete dependence upon the skill, wisdom, experience, even the luck of his doctor. His convalescence was not marked by any special diets, no champagne jellies, no nourishing soups, no prescriptions of stout to "build him up." No one ordered a glass or two of port at night. All he had to do was take a few pills for two or three weeks. He was not even ordered to guard against night chills. He did not feel that he had been rescued from death's door. No one suggested that he had been especially lucky to survive. Nowadays we expect to diagnose, treat, and cure most illnesses quickly and efficiently with the least possible fuss; most of the time our expectations are met. No one regrets this transformation, but on reflection (and neither doctors nor patients are usually

reflective about such matters) it is clear that this is unlike the atmosphere which for centuries nourished the doctor-patient relationship.

Many great diseases are now so well controlled by immunization that we are scarcely aware of them. Others like diabetes and tuberculosis can be much alleviated by various forms of screening and earlier treatment. Medicine is far more effective than ever before. One might suppose that since doctors are now able to do so much more for patients, the relationship between them and their patients would be better than ever. Actually, however, patients have become more critical of their doctors, do not heed them more carefully, are more likely to bring legal suit against them, and are as much a prey to quacks and charlatans as ever.

Various explanations have been offered for this. Some psychiatrists say that doctors are "too authoritarian" and suggest that patients should be treated "more permissively." Any physician who being sick has been unlucky enough to be treated "permissively" by a well-meaning colleague knows that whatever the correct explanation may be for the difficulties arising between doctor and patient, this one is bogus. When you are really ill the last thing you want is to be your own doctor. The sick person's desperate need is for someone to take full responsibility for combating his illness and getting him well. The "permissive" doctor is a contradiction in terms. The physician's function is to accept responsibility for the patient and his illness, to lay down the best course of action known, and to ensure that the patient adheres to it—however frightening, painful, dangerous, and abhorrent this may be. Medical men have been extremely successful in doing this, generally speaking, by offering what is in fact only their advice: advice backed by the clear understanding that if it is not taken, the illness will get worse and death may ensue. In addition, the doctor, if his advice is rejected, may withdraw from the case, and as Ecclesiasticus puts it:

Let him not go from thee
For thou hast need of him.

Medical advice is taken so seriously because of the penalties which may be attached to ignoring it. This is why it is so often called doctor's *orders*. An unfavorable medical opinion is sometimes referred to as "a sentence of death." Such figures of speech reflect the way people perceive illness and the penalties associated with it, which are suffering, maiming, and death. In the drama in which we are likely to play a leading part at least once in our lives, the medical man occupies an extraordinary variety of roles, for he may be seen as detective, judge, jury, counsel for the defense, chief prosecutor, a member of the appeal court, the issuer of reprieves, executioner, and even as an organizer of jail-breaks and last-minute rescues. It is not surprising that doctors and patients alike are likely to be confused by such a complication and multiplicity of roles.

Generally speaking, the medical profession takes this all very much for granted whether one considers students at the start of their long novitiate or those who occupy the most exalted professional offices. Doctors are practical men who deal with practical matters rather than bothering about theories. By this they mean treating the sick whom they see in their everyday work rather than concerning themselves with abstruse social relationships which don't seem to them to make sense. There is a further complication, sometimes glossed over or held to be a temporary evil: increasing specialization. The doctor-patient relationship developed in eras when it was at least possible to imagine that a single man might encompass not only the whole of medicine but, with a little more ambition, the whole of science. Today, no one can entertain such self-deception. Specialization has been followed by sub — specialization. A technical medicine of the laboratory, hematologic, biochemical, bacteriologic, electrophysiologic, radiologic, pharmacologic, and psychologic has grown up without which diagnosis or treatment would often be difficult — if not impossible. Responsibility for both diagnosis and treatment of patients must now be shared by many people. This has altered the doctor-patient relationship. And this change will

continue. It seems unlikely that the traditional doctor-patient relationship can ever be revived. But it is possible that many of the present problems will be solvable only if we discover exactly what they are. One doctor should surely be responsible for ordering and coordinating (administering) the many different aspects of medicine which can be brought to bear for a patient's benefit. The family doctor is usually the best person to do this. But to be effective in such an exacting task, calling for judgment over such a wide range, he will have to be given an appropriate education. At present, in the great teaching hospitals dominated by specialists, there is not much evidence that anybody is concerned about this. The old profession continues to be essentially a craft or guild and changes even more slowly than most trade unions have under the spur of automation.

Illnesses, however, have been changing in an astonishing way for the last fifty years and more; and with this, public attitudes toward illness and health are changing, too. Perhaps public attitudes are changing more quickly and radically than professional ones, for medicine has always been very conservative and traditional. The aphorisms of Hippocrates written 2400 years ago to give clinical guidance to his colleagues still make excellent sense. Medical students in their late teens and early twenties accustom themselves to death in the dissecting room and then to suffering and dying in the wards. Young doctors learn early and repeatedly that life is tragic and uncertain. Then they assume that their patients will share a point of view which seems so self-evident to them. Indeed, until very recently it was self-evident, but due to the prodigious exertions of medical scientists and the use of their discoveries in hospitals, offices, and clinics it may no longer be so. People are beginning to believe that illness can and should be prevented. When this is impossible, they feel that it should be treated successfully, that pain can be controlled, and that recovery will be complete. Anything less than this is a disappointment. So well has medical achievement been assimilated that public officials can now discuss "the right to health," as if reasonable people must accept that such a right exists. This is worth some thought. A legislator who proposed "a right to good weather" would be considered eccentric, and no party would endorse such a right. It shows the extraordinary confidence in which medicine and its practitioners are held that "the right to health" ever receives serious consideration as part of a political platform. Public confidence is not misplaced, for medical discoveries such as water purification, immunization, mass x-ray, the destruction of insects carrying disease, the addition of vitamins to foodstuffs, or their distribution at clinics — turned into public health routines — are eliminating massive illnesses. Yet gratifying as this confidence is, it has altered, and cannot avoid altering, the relationship between doctor and patient. It is ironical that the miracles of good health, of recovery from illness, and from the threat of imminent death which for millennia sustained an extraordinarily stable doctor-patient relationship should, due to the efforts of research, now become "the right to health." For while men are properly grateful for miracles ("For of the most high cometh healing") which are unexpected and unimagined benefits, no one is expected to be grateful for being accorded his rights. Why *should* anyone be grateful for rights? Rights are, by definition, those things to which we are entitled.

The public may be correct in believing that they have a right to health. If so, it must then be prepared to provide and maintain conditions in which good health can exist. The relationship between doctor and patient, however, cannot be the same when the emphasis shifts from the relief of suffering to the right to health. Such a right implies that ill health is preventable and that sickness must be due to insufficient effort at prevention, or even due to negligence. Pain and suffering, once the common lot of mankind to be endured but never escaped, are now seen as infringements of the right to health. Indeed, this restoration of health occurs so frequently and effectively that we can hardly avoid taking miracles for granted. A miracle that has become a routine is no longer a miracle. Yet

there are many medical men now in their middle years and older who have lived through a time in which patients who once died miserably now survive and prosper. Such men find it frivolous, blasphemous almost, to accept these miracles as routines, yet they do it all the same. It is the extraordinary progress of medical science which has made it impossible to play the doctor-patient relationship by ear any longer. It must be explored, its function and purpose understood, and the relationship redefined in the social context in which we live today. Medical authority has its roots deep in time, stretching far beyond those doctor gods Imhotep and Aesculapius, in a world where disease was hugely powerful and mysterious and could properly be attributed to sinning against one's Maker; where healing came from on high and where the doctor mediated between the sick and those dangerous higher powers. Medical authority derives from the belief that the physician gives good advice and performs skillfully to help the sick to the best of his ability. If this "authority" is to be invoked in the complicated and changing world in which we now live, doctors must understand it well enough to exercise it for the good of their patients. With such authority — that of advising for the best — and the admiration and awe which accompany it (when the advice succeeds) — goes great responsibility. Patients expect doctors to be wiser, kinder — in brief, better than other men. When these expectations are disappointed, which is inevitable, patients take it more to heart than with those for whom they have less regard. Doctors sense this disillusionment and respond to it with shame, guilt, impatience, or chagrin, depending upon their temperament.

Some of the clashes and conflicts now occurring between organized medicine and governments may arise, in part at least, from a failure to grasp the implications of this very new belief that health is a right to be exercised by every man, woman, and child in the world. The public, who from time to time become patients, are, it seems, more convinced that this right does exist than are most medical men themselves. The public are becoming less disposed to consider that health is a privilege, even a privilege dispensed by the most benevolent doctors. A right cannot be an object of charity, for if it were it would not then be a matter of entitlement. However, even supposing that this newly-perceived right becomes widely accepted, the physician still maintains his right to demand "the honor due unto him for the uses ye may have of him." Health and healing are still seen as coming from the most High, and their furtherance is seen by patients and doctors alike as being good. We do, however, need more adequate and apt social arrangements by which doctors and patients and the public can play their part in reducing illness; and, not only maintaining, but extending health. We also need ideas expressed in suitable words that will allow us to understand better the extraordinary changes of the last hundred years, when the daughter sciences of medicine have begun to remodel their old, enduring but rather dowdy mother so vigorously that when she looks in the mirror of the times she can hardly recognize herself.

Box 1000

1967 Annual Meeting

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Haddon Hall, Atlantic City

Government's increasing responsibilities are exposing psychiatrists to "political" processes and pressures—and it is well that psychiatrists adapt to this if they wish to maintain leadership.

Social Phenomena And The Physician:*

The Effect Of Government Upon His Services

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The American physician, whether in public service, on the house staff of a voluntary agency, or in private practice, is involved in politics and government. Medical practice (and this includes psychiatry) is surely part of, and is affected by, political processes and governmental decisions. Professional organizations, to some extent, by using political technics, function to protect the profession from certain forms of intrusion, particularly those operationally defined as "professional decisions." Yet, the American people through the federal, state, and local governments make public policy for health, mental health, and medical care. In recent years, support for training in medical education, public health and related personnel, and programs such as Medicare, the community mental health center and retardation facilities, and the "staffing amendments" are outstanding examples of such public policy; a policy which is basically political in its origin, in its support, and its implementation.

Elected officials have not been alone in setting the legislative pattern; but without political partisan action these trends in the philosophy, organization, financing, and delivery of medical care could not have been developed. Physicians, including psychiatrists, do not as a rule like to think of themselves as involved in the political process, and it is not strange to hear psychiatrists and other MD's in public office denying that they have political functions and contrasting "professional" and "political" roles. Community psychiatrists,[1] however, have recognized the relevance of the political process to their specialty, perhaps because in their roles they are clearly faced regularly with political issues.

Mental health as a *clinical* activity involving a role relationship of therapist and client can hardly be defined as "political." But mental health as activities involving leadership in planning mental health services; organizing community patterns of care; administering a mental health program, department, or board; promoting mental health values and concepts in society; implementing professional views on mental health priorities and problems; or developing "plans for social programs and resources" (as *Psychiatric News* described Dr. Leonard Duhl's new position in the Department of Housing and Urban Development) clearly cast the psychiatrist in the center of interest of political science. Funds, decisions supporting proposed professional care programs, and interrelations with other health, social, or welfare programs all are among the subjects of political activity with

* Read by invitation before the Section on Psychiatry, Annual Meeting of The Medical Society of New Jersey, in Atlantic City, May 16, 1966. The authors are from the Department of Government at New York University.

[1] Caplan, Gerald: "Community Psychiatry" in Goldston, Stephen E.: Ed., *Concepts of Community Psychiatry: A Framework for Training,* USDHEW PHS Public Health Service No. 1319, 1965.

which psychiatrists have to deal as professionals. All these factors, in turn, are not isolated ventures of community psychiatry; directly or indirectly they affect the whole system of psychiatric care, including the context of private practice which cannot be divorced from other medical, social, and psychiatric resources in the community.

More involvement and participation of the psychiatrist in political activity will be required as the trend for comprehensive community mental health care becomes firmly established as an empirical reality. The planning and development of new comprehensive community mental health centers is in many ways contingent upon the continuous support that psychiatrists receive from their communities, their leaders, their legislators, and other elected officials. The community mental health center is a part of the political power structure. Many times public acceptance or rejection or indifference to mental health services has been conceptualized as "social attitudes," but very few times are these social attitudes viewed as emerging potential or active sources of organized support or organized opposition to mental health plans. Yet, this recognition is crucial to the chances for successful implementation of comprehensive community mental health service planning and programming. If really comprehensive, the community mental health center will have the major responsibility for coordinating and strengthening all other mental health and relevant services within its own catchment area of service. In metropolitan areas, this may involve county, city, state, voluntary, and Federal agencies; psychiatric, other medical, psychological, social work, and rehabilitation agencies; each with its own tradition of professional independence and autonomy, special clientele, sources of funds, and controls. Then there are the new antipoverty agencies with their goal of developing social competence among the deprived populations and their expanded source of power; the leadership of the poor, and their use of new pressure groups and technics not used traditionally by middle-class leadership—such as vigils, boycotts, and marches. Now this population, which was a passive and largely unorganized constituency, is becoming an increasingly vigorous political force. It is in a society in which the distribution of power is finding a wider base and in which conflict and opposition can find vocal and political expression that the community mental health centers and the future of psychiatry are being tested.

Federal regulations suggest that community mental health centers should serve "catchment areas" of 75,000 to 200,000 population. Is this the population design of American communities? Obviously not. In rural America this may involve several communities under several governments being brought together under the aegis of the center; in metropolitan areas, it may require creating new communities, cutting across traditional lines of community identity. The community mental health center is a new American institution which may further alter the locus of political power and institutional arrangements. The centers may require relocation of peoples to be appropriately situated for accessibility; they may become important sources of jobs, they may bring in hundreds of people to work there; furthermore, to comply with regulations, their "catchment area" may include antagonistic groups including militant anti-mental health groups. These problems and challenges will have to be faced, but tools will have to be developed for their control.

Therapeutic concepts and technics, of course, are neither adequate nor sufficient for this confrontation. The processes involved are distinctly in the political level. In these matters the psychiatrist has to develop lines of communication with politicians, inform and educate them about mental health problems and solutions, and whenever possible make appearances at legislative hearings or take a public position to gain wider support for the mental health plans and programs. The maintenance of comprehensive services within a coordinated system of care is only possible if the directors of centers assume leadership in turning this institution into a creative social force. This means that many times these psychiatrists will have to raise and shape issues

and influence decision-makers for the mental health program of the community.

How, you may ask, can this expanded role be assumed by professionals who have a medical mission? Community psychiatrists have started to recognize this extended professional role. The movement, however, needs acceleration in view of "the advent of the center."

The "politics" of community mental health is so complex that in the past three years under an NIMH grant we have been training, at New York University, Ph.D.'s in political science with a specialty in mental health. As scientists-professionals, these political scientists will be concerned with problems of community power structure, roles of mental health and related professions, processes of group organization, leadership and activity, intra- and inter-governmental processes and relationships, the legislative and judicial process, and other socio-political processes bearing upon decision making, mental health planning and organization, delivery and effectiveness of services.

These political scientists are being trained as a new kind of operating professional in this rather complex, general and yet highly specialized area of political behavior and mental health. Development of this kind of personnel by no means excludes the responsibility of, or need for, competence among psychiatrists and other mental health professionals in the political process; it is clear that as psychiatry moves closer into comprehensive community mental health care, there will be a need for psychiatrists manifestly to recognize that a political role will be an integral part of the function of psychiatry, either to be discharged by psychiatrists themselves or by other professionals in their behalf.

Summary

The increasing responsibilities taken by government in mental health care have placed psychiatry as a profession in the midst of shaping and carrying out public policy. This continually exposes the psychiatrist to the political process and to the need to be responsive to public issues affecting mental health care, training, research, planning, and delivery of services.

New York University

Effects of Cigarette Smoking On Spirometric Performance

Spirometry was performed with a 13.5 liter Collins recording spirometer in 410 healthy community-dwelling men ranging in age from 20 to 103 years. Subjects were classified as nonsmokers, current cigarette smokers, former cigarette smokers, and pipe and cigar smokers. Evidence that cigarette smoking impairs ventilatory function was twofold: current cigarette smokers had significantly lower vital capacities (VC), one-second timed vital capacities (FEV 1.0), and maximal voluntary ventilations than nonsmokers; partial regression analyses for current cigarette smokers indicated that the greater the consumption of cigarettes the lower were VC, FEV 0.5, and FEV 1.0. Similar analyses for former cigarette smokers indicated that the greater the number of years of smoking the lower were FEV 0.5 and FEV 1.0. Also, a significant positive relationship was found between smoking-free intervals and VC, FEV 0.5, and FEV 1.0 in former smokers. Cigarette smoking seems to impair ventilatory function in subjects who appear healthy upon clinical evaluation; this effect is related to the amount of cigarettes consumed and is reversible upon cessation of smoking.

N. H. Edelman *et al.*: Amer. Rev. Resp. Dis. 94:421, (Sept.) 1966

The missing ingredient in doctor-patient relationships is time. Here are three proposals to make more "effective" time available to the physician.

Health Care Demands and Suggested Changes in Medical Practice

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Every age considers that its own period is one of crucial change and decision-making—that the time of crisis is here and now. And, of course, the present era is no exception. Indeed, we are now faced by a series of important changes and problems; perhaps not necessarily a crisis, but certainly a rapid rate of evolutionary change. And this rapid rate of change is affecting the most important single component of the practice of medicine: the physician-patient relationship. It is upon this interaction that the structure of our profession depends. Any atmosphere of implied crisis may well be a consequence of the fact that there is widespread concern that the satisfying aspects of the physician-patient relationship are being seriously eroded. It is the purpose of this essay to review the problems which make a satisfactory physician-patient relationship more and more difficult to establish, and then to attempt to identify a solution to these problems.

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Consider first the rising demand from all quarters of the nation for health care services. Note the increasing difficulty on the part of the profession adequately to provide that care. Wherever one turns—urban heartland or rural hinterland—physicians talk of the press of patient care demands: there is too much to do and not enough time to do it in; too many people to see and just not enough time to see them in the way it should be done. There are more patients than ever. The rate of increase among physicians has not matched the rate of rise in the number of patients. This is, in part, a consequence of the fact that people are living longer, and, therefore, there are more individuals with significant decrements in organ function and with degenerative disease. There are other factors: in recent decades, our population has been rigorously health-care educated, so the need for physician services is now more widely appreciated. Furthermore, the increasing number of patients has not only been a quantitative problem: it has also been a qualitative problem. The kinds of patient problems that now confront the physician are of increasing complexity and difficulty; the patient comes not with just one illness, but rather with a whole complex of disorders. As the chronicity of illness develops, the added multiples of other diseases are superimposed. It is rare that the physician is faced by a patient who presents just a "simple" problem; more often, he sees a patient in the midst of an array of disabilities. At one time we thought this view was

primarily a biased perspective which developed out of having been located in a university hospital dealing primarily with referred patients; however, after visiting several community hospitals in our area and after talking with many general practice groups, it is clear that the complex and multi-illness patient is a general problem for all physicians. Thus, not only is the physician being asked to see more patients than ever before, but the patients themselves have more difficult problems.

These two elements alone would suffice to explain why the most valuable component of the doctor-patient relationship—available time—is in very short supply and, therefore, creating a serious threat to the relationship. Other factors must also be mentioned, though in part they are a consequence of the two already outlined. One is that as medical problems have become more complex and more difficult, the physician has called upon a number of additional people to help him design more complex and more elaborate technics to handle these problems. Therefore, what physicians do has now become highly elaborative and specialized: multi-staged diagnostic procedures utilizing special machines and personnel; artificial organs and mechanical aids for cardiac, renal, and respiratory functions; multiple-phase programs of physical, occupational, social, and educational therapy, all of which require special knowledge and specially-trained personnel. For the physician to use these newer forms of complex diagnostic and therapeutic modalities, he must become reasonably familiar with them himself; and as the prime educator on the health team, he must participate in the training of others to be able to provide these special skills.

Finally, once having completed one round of education—the physician cannot consider himself as being through. The very fact that the problems are more difficult — and that a larger number of individuals are working at their solution—has meant that the body of information and knowledge about health and disease has grown enormously. The only way the practitioner can avoid instant obsolescence is to maintain a program of continuous (not continued) education. For the physician, any pause in the educational experience is not one that refreshes, but rather one that leads to confusion and despair.

In summary, then, the elements of increased numbers of patients, increased difficulty of patient problems, more complex diagnostic and therapeutic procedures, and more intensive need for continued education are all placing increasing demands upon the physician's time and skill. And as the time available for each individual patient shrinks, so does the satisfactory quality of the doctor-patient relationship. It would appear clear, then, that any set of processes that would give the physician more "effective" time for the individual patient would help to revise this unfavorable pattern. For without a satisfactory physician-patient interaction, there is little excitement and personal reward in the process of doctoring.

We propose major changes in three general areas as a solution to the problem of providing more "effective" physician time: *first,* the development of a new group of health care experts, individuals we have elected to call physician assistants; *second,* the widespread introduction of automated and computer-monitored technics for laboratory and history-gathering procedures; and *third,* the purposeful development of sophisticated skills in interactional processes for all physicians.

Physician Assistants

The development of physician assistants is a program which is aimed at the aspects of the problem centered primarily around the more complex specialized procedures of health care: renal dialysis, respiratory airway maintenance, intensive cardiovascular support. All of these entail highly elaborate machinery, sensitive electronic equipment, and complex procedural sequences that require special interests and skills. Among the large number of personnel available to help physicians in the past, the nurse has been asked to participate in these procedures. She has been considered to be the level of person that has had sufficient

educational background. The licensed practical nurse, the nurse's aide, and the laboratory technician did not have sufficient biological training. But the demands of the procedures have now out-distanced her interests and skills. Many of the units are focused more upon the machinery than upon the patient. The nurse's interest traditionally has been primarily upon individual, person-centered patient care. Furthermore, these highly elaborative modalities require a long-term commitment to involvement in such units, and the intermittency of a nurse's work career (often a consequence of her role as a mother and homemaker) has meant that she cannot always maintain her training. Thus, there is a need for a person to sustain a life-long work pattern in health care, working primarily in the procedure-oriented area of medicine. The model for such a person was developed in the armed forces in the role of the medical corpsman. The extension and elaboration of this role in the hospital and office practice of community medicine may be viewed as the *physician assistant*.

At first glance, the physician assistant may appear as a relief person for the nurse rather than for the physician. In actuality he will provide greater flexibility for the physician, for there will be continuity of competence at a difficult level of performance, assuring the doctor that he may turn his attention back to the patient from the machines. In the arena of the office practitioner, the physician assistant will also provide an opportunity for complex and involved procedures to be done on an ambulatory basis, and, thereby, permit many more patient care activities to take place in the practicing physician's own work place. Such procedures as intermittent positive pressure breathing, airway care, peritoneal dialysis, prolonged continuous blood glucose monitoring, cardiovascular-assistive periods will thereby become part of daily *office* practice. Thus the level of technical competence of the health care area closest to the patient and the physician—the private physician's own office—will be considerably upgraded and expanded.

The appearance of a new person on the roster of health care personnel in the community will mean that both physicians and patients will have to be informed. There will be reluctance in several quarters. Patients will be unfamiliar with the role of a corpsman in office practice. Physicians may feel they are abdicating one more facet of their work skills. But there are new opportunities in the development of such a person, and it is the opportunities which require emphasis.

Automation

Whenever the topic of automation and computers is mentioned in relation to the care of patients there is the immediate question of further depersonalization of the physician-patient relationship. The answer is that the systematic ordering and the extraordinary speed and infallible memory that such units can bring to health care activity can provide more flexible use of both the patient's and the physician's time. The recent report of Collen[1] demonstrates clearly that the initial visit of the patient to the physician can be complemented efficiently and precisely by the automated processing of many laboratory observations. The entire procedure of detailed history gathering and the potential clinical significance of such information could all be facilitated by computer-based technics. The objective of such units would be to move the point of departure for the doctor-patient interaction further along into the decision-making and evaluative phase than it now stands. It would mean that when the physician actually began seeing the patient he would already have at hand a considerable amount of historical and biological information, thus freeing his time and energies to be able to focus on the specific and personality-dependent needs of any one individual patient. This would allow the physician to begin the process of analysis and decision choice much earlier in the care of the patient, and always with a firm sense of assurance that the myriad of historical and screening details were already reviewed and catalogued. Computer technology and the skills of systems analysis can now be applied to the daily office practice of medicine, and these programs offer a remarkable degree of surety and comprehensiveness for the process of data acquisition from patients.

As with the introduction of a new class of health care personnel, the introduction of a new pattern of machine-based history taking and initial screening will produce patterns of reluctance and reserve. These units are expensive, but computers can be shared by many users. If a whole community of physicians were to develop interests and skills in the use of computer-based technics, then the individual practitioner could time-share these extraordinary facilities at an individual cost no greater than the amortization of an office x-ray unit. The key here again is the education of the patients and the profession. If we are to free ourselves from the pressing restraints of present-day demands we must explore these new and innovative realms.

Interactional Skills

Most of us were trained in medical schools where the development of specific technics in how to talk and listen to patients was the responsibility of the psychiatrist. And most of us quickly came to believe that such skills were to be used only for psychiatric problems, and that the intuitive, "natural" abilities of the physician were applicable to all other patients. We submit that this association of specific skills in interactional procedures only with patients with psychiatric illness proved misleading. The basis of the successful structure of the doctor-patient relationship is the meaningful transmittal of the patient's highly personal feelings to the physician. Once this is accomplished, the patient—and the physician—regard the interaction as satisfactory. The skill and technics required for the physician to get this task done as efficiently and as rapidly as possible derive from the behavioral scientists and the discipline of psychiatry. These skills are applicable in internal medicine, surgery, obstetrics—wherever one practices medicine.[2] The physician may work at the doctor-patient relationship not as a chance phenomenon, but very purposefully and precisely, comparable to any other professional skill he brings to his job. Mastery of these modalities will allow him to see more patients over a shorter period of time, and to have the doctor-patient interaction evolve as a satisfactory and satisfying investment for both himself and the patient.

The methods of the behavioral scientist can be utilized to facilitate and expedite the doctor-patient relationship. These same procedures may be extended to include several patients at one time. Thus the procedure of seeing patients as a group — individuals with similar disease processes or comparable patterns of disability—can be an effective means of dealing with the concerns, anxieties, and doubts of patients. The purpose of such sessions is to communicate to the patient that the physician—or the appropriate health care individual—understands and accepts these unpleasant feeling states. Since patients almost invariably experience such feelings, the group meetings provide an opportunity for them to share these concerns with other individuals. The method in behavioral science is termed group therapy, and it can be usefully applied beyond the arena of classical psychiatry. Of course, the conversation and discussions that take place in the waiting rooms may provide for some of these interactions—but the planned and directed management of such group discussions again takes the matter out of the realm of chance and places it squarely into the province of professional purpose.

Conclusion

Three types of innovative change may be implemented into the practice of medicine within the near future. One is the utilization of physician assistants. Here, it will be necessary for many medical centers and community hospitals to create training programs and to develop such personnel. We have already initiated such a program at our medical center*, and are learning how such a program may be most effectively designed.

We should expand the use of computer-assisted procedures. Several medical centers and computer corporations are developing individual systems. These approaches will be available to community hospitals in the near future. This would appear to mean that community physicians might well anticipate these oppor-

tunities by arranging for some local instructional programs in computer principles and methods.

The application of behavioral science skills to all of medical practice should mean further reflection and review on the part of the physician. Here, again, he must call upon the local experts to come in and provide highly-focused instruction and supervision.

The medical profession is being heavily pressed by the increasing demands for health care. To meet these demands, it is necessary for us to work out new approaches and methods. The pathways we have suggested have in common the characteristics of introducing major changes in perspective for both the patient and the physician, and, in addition, place a further demand upon the educational evolution of the practicing physician. But there are no easy answers to these problems, and if we are to sustain the excitement and satisfactions of our work, we ourselves will have to extend our skills and provide the imaginative leadership in encouraging new changes and innovations.

Bibliography

1. Collen, M. F.: Periodic Health Examinations Using an Automated Multitest Laboratory. JAMA 195: 142, 1966.

2. Bogdonoff, M. D., Nichols, C. R., Klein, R. F., and Eisdorfer, C.: A Suggested Practical and Purposeful Approach to the Doctor-Patient Relationship. JAMA 192:45, 1965.

Duke University Medical Center

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal is the official organ of The Medical Society of New Jersey, published monthly under the direction of the Committee on Publication. *The Journal* is released the first week of the month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey, 08605.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of any material in *The Journal.* All such communications should be directed to the Editorial Office of *The Journal.* The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted.

Contributions: Manuscripts submitted to *The Journal* must be typewritten, double-spaced on letter size (about 8¼ by 11 inch) paper, and forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not; and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal.* Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit original copies only, and are urged to keep carbon copies for reference. It is understood that material is submitted here for exclusive publication in this *Journal.*

Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original sketches, from which cuts or plates will be made by *The Journal.* The cost of making such cuts will be borne by the author, who will, after publication, receive the cuts for his own use. The cost of these cuts varies with the size and type of the illustration.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P. O. Box 904, Trenton, New Jersey 08605

STATE ACTIVITIES

Trustees' Minutes

September 18, 1966

A regular meeting of the Board of Trustees was held on Sunday, September 18, 1966, at the Executive Offices. For your full information, detailed minutes are on file with the Secretary of your component society. A summary of the significant actions follows:

Medicare . . . Reaffirmed its conclusion that the action of the Council on Medical Services in recommending approval of the proposal from the Division of Public Welfare was not at variance with resolution #18 (Compensation of Physicians for Care of All Patients) adopted by the 1966 House, because it had been taken with full cognizance of the stipulation of the resolution that billing by physicians should be on "their usual and customary fee-for-service basis" (see page 529).

Rutgers Bicentennial . . . Authorized the presentation to Rutgers University Library during its bicentennial celebration of a copy of *The Healing Art.*

Wisconsin Medical Society . . . Received with appreciation a framed citation presented by the Wisconsin Medical Society on the occasion of MSNJ's bicentennial.

"Eye Start" Pamphlet . . . Noted with appreciation the offer of the New Jersey State Department of Health to underwrite the expenses of an additional printing of five thousand amblyopia pamphlets.

11th Trustee . . . Referred to the Secretary of the Society, for transmission to Standing Committee on Revision of Constitution and Bylaws and to each component society, a resolution from the Morris County Medical Society requesting amendment of MSNJ's Constitution and Bylaws to eliminate the office of "11th Trustee."

The Healing Art . . . Agreed on December 31, 1966 as the cut-off date for new members to receive a copy of *The Healing Art* as a benefit of membership.

Diet Regimen in Hospital . . . Received the opinion of counsel to *HSP* that, since New Jersey Blue Cross contract contains a specific exclusion of certain hospital services (including diet therapy), the New York decision (directing Blue Cross payment to a hospital wherein a patient was treated for obesity by a starvation diet) will probably not be an applicable precedent for New Jersey.

AMA Clinical Meeting . . . Authorized the following to attend the AMA meeting, to be held in Las Vegas on November 27 to 30: President, President-elect, Executive Director, seven regular delegates, and two alternate-delegates (Dr. John E. Kustrup of Trenton and Dr. Matthew E. Boylan of Jersey City).

AMA House Schedule . . . Authorized the presentation by the New Jersey delegation of an appropriate resolution, urging revision of the AMA schedule of the House of Delegates and its reference committees to allow more time for delegates to study, evaluate, and prepare positions concerning matters submitted to and reports from reference committees.

Actuarial Survey . . . Endorsed approval of the Committee on Medical Defense in accepting the "Actuarial Survey of Professional Liability Insurance Program as of April 30, 1966," which seemed to substantiate the expectations indicated by American Mutual in 1960, when it was approved as the official carrier for MSNJ's liability insurance.

. . . Accepted the conclusions of the actuarial survey as follows:

1. The members of the Society have taken a forward step in an effort to solve the vexing problem of professional liability coverage.

2. While cost of insurance is not necessarily the most important element, the existence of a ready market for practically all members cannot but have a beneficial effect on the level of premium rates.

3. The carrier (AMLICO), in making its records available to a representative of the Society's own choosing, has evidenced its good faith.

4. The data examined, which formed the basis of this report, indicates that the interpretation of the data being compiled is reasonable.

5. Probably most important, the machinery has been set up whereby the medical profession is in a position to take positive steps in the direction of prevention and control of the losses which are the essential ingredient of premium rates.

Constitution and Bylaws . . . Concurred in the opinion and conclusions of the Study Committee on Constitution and Bylaws, as reflected in the following:

The special study committee — appointed by the Board to carry out the directive of the 1966 House of Delegates "that a special committe study the recommended revision to the Constitution and Bylaws concerning the Procedure of Election, Chapter V, for report to the 1967 House" — considered the amendment proposed by the Union County Medical Society to the 1966 House, including the remarks of the reference committee.

It was the unanimous opinion of the committee that "a reapportionment of voting strength within the Nominating Committee, as proposed in the (1966) Union County Amendment, is not desirable because the populous counties — in consequence of their greater number of delegates — can proportionately influence the election itself and thus have a strong impact upon the choice of elected officials of the Society. To modify the present voting balance within the Nominating Committee might lead to discouragement of nominees from small counties and result in nominations from the floor that would unnecessarily lengthen the election sessions of the House of Delegates."

The members of the committee, therefore, unanimously voted *to recommend* that no change be made in the apportionment of voting strength within the Nominating Committee.

. . . Agreed that the following report of the Study Committee be placed on the agenda for the meeting of the county presidents:

The committee then considered the possibility of a more radical reapportionment of county representation by re-districting the entire state. After extended discussion, those present agreed that such a step would involve the entire judicial mechanism and organizational structure of the Society; that the disadvantages of such a drastic change would be more complicated than helpful.

In line with the above discussion, the commitee was made aware that at least one county (Morris) has submitted a formal resolution for presentation to the 1967 House of Delegates recommending the elimination of the office of eleventh trustee.

Those present explored many possibilities and came up with the following alternative proposals:

1. That the office of eleventh trustee be discontinued, upon expiration of the term of the incumbent.

2. That, because of the concentration of membership in Essex County, Essex County be made a separate district, to be known as the "Sixth District." (Creation of a Sixth District would put an additional two elected members on the Board of Trustees, bringing the total to 12 instead of 11 as at present.)

The committee agreed that the foregoing proposals should be discussed with the Board and, with Board approval, be included on the agenda for discussion at the meeting of county presidents. After the committee has had some indication of the reaction to these alternatives, it will meet again to form more definite recommendations for subsequent submission to the 1967 House.

The committee agreed that its next meeting should be held in late November or in early December.

. . . Raised the following alternate proposal, which was referred to the Study Committee for further investigation and evaluation:

That the Board of Trustees be composed of the regular officers and twelve (12) members — two from each Judicial District and two elected "Trustees at large" in permanent status under that designation.

Historical Society . . . Withdrew the loan stipulation and gave to the New Jersey Historical Society the drawing by Homer Hill, which was used for the dust jacket of *The Healing Art.*

Negro Physicians . . . Considered a request from the AMA for the names of negro physician-members who are members of the AMA and whom MSNJ "feels, because of their interests and abilities, should be considered by the AMA Nominating Committee for AMA committee membership;" directed that the following sentiments be incorporated in a letter to the Executive Vice-President of the AMA:

The Board unanimously agreed that the request from the AMA is violative of the essential spirit of MSNJ's Resolution #75 submitted to the AMA House in 1966. MSNJ's files have no identification of members by color. The Board moreover recorded its opposition to the appointment of members on any basis other than their personal, scientific, and professional qualifications and capabilities. The Board recorded its eagerness, however, to submit to the AMA a list of names, without designation as to color, of those members of MSNJ who the Society, feels, because of their interest and abilities, should be considered by the AMA Nominating Committee for AMA council and committee memberships.

August 21, 1966

A regular meeting of the Board of Trustees was held on Sunday, August 21, 1966, at the Executive Offices. For the full information of the membership, detailed minutes are on file with the Secretary of each component society. A summary of the significant actions follows:

Heart Disease, Cancer, and Stroke . . . Noted that President Jehl has been elected chairman of the New Jersey Joint Committee for Implementation of P.L. 89-239 (heart disease, cancer, and stroke).

State Society Presidents . . . Authorized the President and President-Elect to attend the meeting of state medical association presidents in Chicago this month.

Rutgers University . . . Directed that an appropriate, laminated scroll be prepared for presentation to Rutgers University, in commemoration of Rutgers' bicentennial celebration.

AMA PR Institute . . .Authorized the President and President-Elect to attend the 1966 AMA Public Relations Institute in Chicago.

Division of Employment Security . . . Directed that a letter be sent to the Division of Employment Security, suggesting the adjustment of the fee per examination up to at least $15.00.

Utilization Review in Nursing Homes . . . Authorized Dr. David Eckstein to proceed with his commendable efforts to work out with the Division of Medical Care Administration of HEW details of his "Proposed Outline for Utilization Review in Extended-Care Facilities;" gave authorization to proceed with negotiations with the understanding that the project will not commit MSNJ, in terms of money or staff, for its development and implementation.

Medicare and Major Medical . . . Approved the proposal of the E. & W. Blanksteen Agency to change MSNJ's Major Medical Plan for persons over 65, as necessitated with the advent of Medicare.

Medicare Program . . . Approved the following report and recommendation of the Council on Medical Services:

The Council considered a draft-proposal submitted by the New Jersey Division of Public Welfare concerning compensation of physicians under Part B of Title XVIII of Medicare for services rendered to welfare recipients.

The Division has "bought in" to obtain coverage under Part B of Title XVIII (Medicare) for 14,000 of its Old Age Assistance clients over 65 years of age who are eligible for such coverage. For other clients over 65 years of age (approximately 6,000) who are ineligible to be covered under a "buy-in" contract — (and who therefore may or may not have voluntarily purchased coverage under Part B of Title XVIII) — the Division is proposing to use the Prudential Insurance Company (the "carrier" under Part B) as its fiscal agent and to pay through Prudential for the kinds of medical services which are covered under Part B, on a uniform basis for all welfare clients, whether or not they are in fact covered under Part B of Title XVIII.

The proposal submitted by the Division essentially offers the following:

1. A single "carrier" and a single claim form will be used for Part B physicians' services rendered to patients over 65 years of age who are recipients of assistance from county welfare boards, regardless of whether the payment can be made from Part B funds or must be paid for out of welfare funds.

2. Physicians will bill on their regular and customary fee-for-service basis. Bills will be submitted to the carrier and not to the county welfare boards. There will be no fixed schedule of compensation.

3. There will be no requirement for physicians to request prior authorization from county welfare boards for professional services (of the kinds covered under Part B) rendered to such welfare clients over 65 years of age when there is medical need for more than one or two visits per month — as the present program does require.

4. For all such welfare clients over 65 years of age dealt with under this proposal, physicians will accept an assignment. The carrier will, across the board, compensate physicians accepting assignments on the basis of 80% of their regular and customary fees, including the first $50 annually so billed (i.e., the "deductible").

5. Because of the indigency status of the patients covered by this proposal, physicians will be expected not to attempt to collect the remaining 20% from the patients.

6. Under this proposal, physicians will receive payment (on the basis set forth above) for services rendered to aged public assistance recipients in hospitals and clinics — which is not so under the present program.

7. If the proposal is accepted, the Division's objective would be to make it effective "as soon as feasible, but no later than September 1, 1966."

Recommendation:

That MSNJ approve the proposal of the New Jersey State Division of Public Welfare, Department of Institutions and Agencies, in accordance with which New Jersey welfare clients 65 years of age or older – either under the coverage afforded by Part B of Title XVIII (Medicare) or that supplied by the Division out of welfare funds – will be billed by physicians through the Prudential Insurance Company as "carrier" for both groups on the basis of their usual and customary fee-for-service, with the understanding that: (1) 80% of such fees will be paid by the carrier under the principles of payment set forth in Part B of Title XVIII for the compensation of physicians accepting assignments; and (2) there is no commitment to extend the terms of this proposal to the implementation of Title XIX.

AMA Delegates . . . Approved the report submitted by the AMA Delegates on their attendance at the 1966 AMA meeting; commended the delegates for their activities and accomplishments at the convention.

Payment of Interns and Residents . . . Directed that a letter be sent to the American Medical Association, calling attention to the action of the 1965 AMA House in re-affirming the 1963 general policy of the AMA House in "approving and supporting the principle that Blue Shield medical-surgical insurance benefits should be paid only to private physicians for eligible professional services personally rendered to their private patients."

1967 House Schedule . . . Approved the recommendation of the Annual Meeting Committee that the schedule of the House of Delegates, with an interval of one day between the second and third sessions, be continued for 1967.

Section on Plastic and Reconstructive Surgery . . . Directed that the 1967 House of Delegates consider the recommendation "that MSNJ establish a Section on Plastic and Reconstructive Surgery."

Section on Mental Retardation . . . Referred to the newly expanded Special Committee on Mental Health the request for the establishment of a Section on Mental Retardation.

MSA Board . . . Approved the following nominations for membership on the Board of Governors of Medical Service Administration:

Irving P. Borsher, M.D., Newark
Harry N. Comando, M.D., Newark
Joseph I. Echikson, M.D., Maplewood
Lloyd M. Felmly (retired newspaper editor)
Elton W. Lance, M.D., Rahway
Rudolph C. Schretzmann, M.D., Hackensack
Edward W. Sprague, M.D., Newark
Thomas J. White, M.D., Jersey City

Special/Liaison Committees/Representatives . . . Approved the list of Special and Liaison Representatives and Special Committees for 1966-67, as reported on page 484, September issue.

Committees Discharged . . . Directed that those special and liaison representatives and special committees which had completed their assignments be discharged, as follows:

ACADEMY OF MEDICINE OF NEW JERSEY, CONFERENCE COMMITTEE WITH (Appointed by Board 4/17/66 to explore with a similar committee of the Academy their proposal for an intimate relationship and closer cooperation) Assignment completed.

AGED, N.J. JOINT COUNCIL TO IMPROVE HEALTH CARE OF THE (Created 11/15/59 to assist the principal purveyors of health services in their efforts to improve health care of the aged and to cooperate with the National Joint Council. Equal representation from New Jersey Hospital Association, New Jersey State Dental Society, New Jersey State Nurses' Association, Licensed Nursing Homes of New Jersey, Inc.) On the basis of the dissolution at national level of the Joint Council, the New Jersey Council no longer serves a function.

BICENTENNIAL CELEBRATION COMMITTEE (Established by Board 7/18/65 to supervise 200th annual meeting events and evolve bicentennial scientific program) Assignment completed.

COMMISSION FOR THE BLIND, NEW JERSEY STATE (Liaison established 11/21/65 to organize statewide central planning committee for proposed "Amblyopia Program" for children of preschool age) Program underway . . . assignment completed.

CRIPPLED CHILDREN AND ADULTS, STATEWIDE SPONSORING COMMITTEE FOR NEW JERSEY SOCIETY FOR (Liaison established 2/18/62 to promote elimination of architectural barriers to full use of public buildings by physically handicapped people) Sponsoring committee disbanded in 1964.

MENTAL HEALTH PLANNING STUDY GROUP, STATE (Appointed by State Director of Planning — to serve as Executive Secretary of the Task Force on Medical Practice in Hospitals) Assignment completed.

Medicare in State Institutions . . . Received the following report — and concurred in the committee's opinion as reported:

At its June meeting, the Board of Trustees named a committee, under the chairmanship of Frank J. Hughes, M.D., to investigate a reported state program to purchase Part B (Medicare) insurance for the Medicare-eligible group of patients in state institutions, including the payment of the fifty dollar deductible under Part B. Physician employees of all state institutions will bill for their professional services under Part B for patients in state institutions so covered, and will be required to remit to the state treasury all professional fees thus collected.

Reporting to the Board, Dr. Hughes explained that the program applies only to licensed physicians — not interns or residents — who are employed and compensated by the State for the services involved. The program will effect reimbursement to the State for the services rendered to Medicare-covered patients — with saving to New Jersey taxpayers — and will avoid duplication of payment to employee physicians for services rendered.

Dr. Hughes reported that, in the opinion of this committee, the program encompassed no grounds for objections on the part of The Medical Society of New Jersey.

Complementary Medicare Coverage . . . Referred to Medical-Surgical Plan the alleged discriminatory elements of Blue Shield Complementary Coverage against radiologists.

The Healing Art . . . Approved the recommendation of MSNJ's Historian-Archivist (Dr. Fred B. Rogers) that the painting by Homer Hill which was used for the dust jacket of *The Healing Art* be placed on indefinite loan to the New Jersey Historical Society in Newark.

OWNERSHIP STATEMENT

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of October 23, 1962; Section 4369, Title 39, United States Code)

1. Date of Filing: September 30, 1966.

2. Title of Publication: THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY.

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6. Names and addresses of publisher, editor, and managing editor: Publisher, The Medical Society of New Jersey, 315 West State Street, Trenton, N. J.; Editor, Henry A. Davidson, M.D., 315 West State Street, Trenton, N. J.; Asst. Editor, Miss Theresa E. Goeke, 315 West State Street, Trenton, N. J.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual, must be given.): The Medical Society of N. J., 315 West State Street, Trenton, New Jersey (a non-profit corporation of New Jersey).

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities (If there are none, so state): None.

9. Paragraphs 7 and 8 include, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner. Names and addresses of individuals who are stockholders of a corporation which itself is a stockholder or holder of bonds, mortgages or other securities of the publishing corporation have been included in paragraphs 7 and 8 when the interests of such individuals are equivalent to 1 percent or more of the total amount of the stock or securities of the publishing corporation.

10. This item must be completed for all publications except those which do not carry advertising other than the publisher's own and which are named in sections 132.231, 132.232, and 132.233, Postal Manual (Sections 4355a, 4355b, and 4356 of Title 39, United States Code).

	Average No. copies each issue during preceding 12 months	Single issue nearest to filing date
A. Total No. copies printed (Net Press Run)	8,054	7,925
B. Paid Circulation		
1. Sales through dealers and carriers, street vendors and counter sales		
2. Mail Subscriptions	7,545	7,544
C. Total Paid Circulation	7,545	7,544
D. Free Distribution (including samples) by mail, carrier or other means	333	333
E. Total Distribution (Sum of C and D)	7,878	7,877
F. Office use, left-over, unaccounted, spoiled after printing	176	48
G. Total (sum of E & F—should equal net press run shown in A)	8,054	7,925

I certify that the statements made by me above are correct and complete. Richard I. Nevin, Executive Director
The Medical Society of New Jersey

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—Neal H. Isil, M.D., R.R. #1, Box 161, Fort Madison, Iowa 52627. University of Istanbul (Turkey) 1955. Board Certified.

CLINICAL PRACTICE—George V. Clift, M.D., 217 William Street, Minoa, New York. Columbia University 1958. Board eligible. Internal Medicine—endocrinology.

DIRECTORSHIP — Julian I. Joseph, M.D., 4064 Bronx Boulevard, Bronx, New York 10466. New York University 1955. American Board of Pathology. Community Hospital.

GENERAL PRACTICE—Edward G. Krug, M.D., 142 Merson Drive, Buchanan, Michigan 49107. Wayne State University 1958.

Vincent R. Moloney, M.D., 301 Danube Avenue, Apt. #2, Davis Island, Tampa, Florida. Temple University 1965.

Edmund J. Gaffney, M.D., Jeannette Apts. #312, 130 Long Lane, Upper Darby, Pennsylvania. University of Cincinnati 1960. Board eligible general surgery.

Anthony J. DiCroce, M.D., 1218 Broad Street, Durham, North Carolina. Duke University 1965.

Jeffrey D. Hare, M.D., Dispensary, Fort Douglas, Salt Lake City, Utah 84113. Albert Einstein 1964.

INTERNAL MEDICINE — Michael A. Bokat, M.D., The Clinical Unit of the Tufts-New England Medical Center, 171 Harrison Avenue, Boston, Massachusetts 02111. Albert Einstein College of Medicine 1961. Board qualified, internal medicine; endocrinology.

Francis X. McGinn, M.D., 6601 Broadway, Bronx, New York 10471. New York University School of Medicine 1961.

Alfred M. Derrow, M.D., 76A Bowdoin Street, Malden, Massachusetts. Tufts 1962.

Harold J. Kobb, M.D., 6400 Pinefield Road, Columbia, South Carolina 29206. Jefferson Medical College 1960.

Bernard J. Grimes, M.D., 126 North Linden Avenue, Pittsburgh, Pennsylvania 15208. University of Pennsylvania 1960.

Theodore A. Kowitz, M.D., 19 Millstone Road, Randallstown, Maryland. University of Pennsylvania 1958. Board certified.

Leroy Strom, M.D., 12403 Stretton Lane, Bowie, Maryland.

James A. Robinson, M.D., 170 Castleman Road, Rochester, New York 14620. Columbia University 1961. Board qualified. Available July 1967.

Melvin J. Breite, M.D., 152-72 Melbourne Avenue, Flushing, New York 11367. Albert Einstein 1960. Group or partnership. Available January 1967.

Philip R. Fleishman, M.D., 269 B Eaton Crest Drive, Eatontown, New Jersey 07724. Downstate Medical Center, 1961. Association or partnership. Available July 1967.

Joseph R. Mussell, M.D., 136 Eaton Way, Cherry Hill, New Jersey. Temple University 1957. Board eligible.

Robert I. Raichelson, M.D., 1561-B Dogwood Street, Fort Dix, New Jersey. Syracuse 1961. Group or associate. Available July 1967.

William Pinsky, M.D., 410 Carmen Road, Amherst, New York 14226. University of Pennsylvania, 1961. Desires association in southern New Jersey. Available July 1967.

George I. Salerno, M.D., 2112 Leesburg Road, Columbia, South Carolina. Georgetown 1961. Associate or small group. Available July 1967.

David J. Scott, M.D., 2160 Center Avenue, Fort Lee, New Jersey. New York Medical College 1962. Prefer shore area.

William C. Sherwood, Capt., MC, Landstuhl Army Medical Center, APO 09180, New York, New York. Jefferson Medical College 1959. Group, association, or institution.

Leroy F. Smith, Jr., M.D. 2944 East Derby Shire, Cleveland Heights, Ohio 44118. Medical College of Georgia 1960. Board eligible. Partnership or clinic.

INTERNAL MEDICINE/CARDIOLOGY—Thomas G. Higgins, M.D., Cardiology Branch, Medical Service, U.S. Naval Hospital, Portsmouth, Virginia. Georgetown University 1960. Board qualified.

Richard A. Duchelle, M.D., 9528 South Colfax, Chicago, Illinois. Georgetown University 1959. Work with cardiac-diagnostic group.

Jerome Ruskin, M.D., 926 Lambeth Circle, Durham, North Carolina 27705. Albert Einstein College of Medicine, 1960. Group or association. Available July 1967.

INTERNAL MEDICINE/HEMATOLOGY—David Prager, M.D., 600 Fulton Avenue, Hempstead, New York 11550. Chicago Medical School 1958. Diplomate, Internal Medicine.

NEUROLOGY—Michael H. Schuman, M.D., 249th General Hospital, APO 96267, San Francisco, California. New York University School of Medicine 1961. Private or group. Board eligible. Available August 1967.

NEUROSURGERY—Mario Ludmer, M.D., 256 Highland Avenue, Pittsburgh, Pa. 15229. University of Buenos Aires School of Medicine 1956. Board eligible.

NUCLEAR MEDICINE — Howard J. Cohn, M.D., Nuclear Medicine Section, University Hospital, Ann Arbor, Michigan 48104. New York University 1958. Academic position at a university medical center or setting up and supervising nuclear medicine section in a community service hospital or large medical group. Available Summer of 1967.

OBSTETRICS AND GYNECOLOGY—Birute S. Preikstas, M.D., 729 West Corrington Avenue, Peoria, Illinois 61604. Eberhard-Karls University, Tuebingen, Germany 1949. Specialty training in obstetrics and gynecology.

Irwin H. Roseman, M.D., 134 Sachem Road, North Kingstown, Rhode Island. University of New York (downstate) 1959. Part I of American Board.

Robert E. Lubanski, M.D., 124 Clifton Place, Syracuse, New York 13206. Upstate Medical Center, Syracuse, New York, 1962.

Captain Earl P. Gelman, 5896B Adams Street, Fort Knox, Kentucky 40121. Chicago Medical School 1960. Available March 1967.

OPHTHALMOLOGY—Vivian Chen, M.D., 3475 Greystone Avenue, Bronx, New York 10463. New York University School of Medicine 1962. Board eligible.

Paul Todtfeld, M.D., 1346-B Werner Park, Ft. Campbell, Kentucky, 42223. State University of New York Downstate 1961. Board qualified. Available July 1967.

ORTHOPAEDICS—Clarke Russ, M.D., 9239 Prevost Street, Detroit, Michigan 48228. Albany Medical College 1959. Military service completed 1962.

ORTHOPAEDIC SURGERY—Harold Katzman, M.D., 1840 Ironwood Drive, Fairborn, Ohio 45324. Jefferson Medical College 1959. Board eligible. Available January 1967.

PATHOLOGIST—James Ernst Haines, M.D., Worcester Foundation for Experimental Biology, 222 Maple Avenue, Shrewsbury, Massachusetts. Stanford University Medical School 1955. Board certified in Anatomical Pathology. Eligible in Clinical Pathology.

Jose V. Amorin, Jr., M.D., Box 5, Howard, Rhode Island 02834. U.S.T., Manila, Philippines 1953. Board eligible.

PEDIATRICS — Robert M. Stewart, M.D., 32 Winrooth Avenue, Providence, Rhode Island 02908. Temple University School of Medicine 1960. Military service completed. Solo or group.

Roger Kane, M.D., 7430 Pinedale Drive Columbia, South Carolina. University of New York (downstate) 1961. Board qualified.

Donald L. Errante, M.D., 1837 Seminole Avenue, Bronx, New York 10461. University of Rochester School of Medicine 1960. Board qualified. Group practice—suburban area of northern New Jersey.

Gerald Lieberman, M.D., 1200 North State Street, Los Angeles, California 90033. Albert Einstein College of Medicine 1961. Associateship — solo — West Orange or New Brunswick area.

PEDIATRIC ALLERGY — Fredric A. Schulaner, M.D., St. Christopher's Hospital for Children, 2600 North Lawrence Street, Philadelphia, Pennsylvania 19133. Tufts 1959. Board certified (Pediatrics).

PEDIATRIC AND GENERAL SURGERY—Richard W. Brenner, M.D., The Children's Memorial Hospital, 707 Fullerton Avenue, Chicago, Illinois 60614. Columbia 1958. Board certified—general surgery.

SURGERY—David M. Hirsch, Jr., M.D., 2835 Webb Avenue, Bronx, New York 10468. University of Chicago 1959. Board eligible.

Martin Seidenstein, M.D., Box 1696, 7th Field Hospital, APO San Francisco 96594. State University of New York, 1959. Partnership or group. July 1967.

Edward Mardini, M.D., (Capt., MC), 127 Luzon Drive, Fort Bragg, North Carolina. Georgetown University Medical School 1957. Association or group. Available July 1967.

Donald J. Sherman, M.D., 1119 East Sharpnack Street, Philadelphia, Pennsylvania 19150. Hahnemann Medical College 1959. Southern area or East Orange.

CHEST AND GENERAL SURGERY—Ronald J. Yadusky, M.D., 75 A Clifton Place, Jersey City, New Jersey 07304. Jefferson 1957. Board certified in surgery.

GENERAL SURGERY—Joseph J. Voytek, M.D., 417 Mechanic Street, Fort Atkinson, Wisconsin. New York Medical College 1949. Board eligible.

GENERAL AND/OR VASCULAR SURGERY—Lester P. Eidelhoch, M.D., 240 Cherry Hill Drive, Bridgeport, Connecticut 06606. New York University College of Medicine 1956. Board Certified.

SURGERY AND GENERAL PRACTICE—Ralph N. Lee, M.D., Veterans Administration Hospital, Fort Howard, Maryland. Howard University Medical School 1960. General surgical residency.

COMMUNITIES SEEKING PHYSICIANS

The following communities have written to the Executive Offices of MSNJ seeking information on possible physicians to fill vacancies. The information listed below has been supplied by the communities and verified by the counties. If you are interested in any further information concerning these communities, we suggest you make inquiries directly of them.

LONG VALLEY (WASHINGTON TOWNSHIP) — Morris County, population of 4500. General practitioner preferably; or obstetrician-gynecologist or pediatrician. One other general practitioner in community. Contact Mrs. David Bressler, Coleman Road, Long Valley, New Jersey; or phone 201-876-3757.

SEVERAL IN SALEM COUNTY, YOUNG GENERAL PRACTITIONERS—New Jersey Chapter of the American Academy of General Practice offers individual services to counsel and introduce to the communities interested physicians. Contact William L. Sprout, M.D., 69 Market Street, Salem, New Jersey

ULYSSES (POTTER COUNTY) PENNSYLVANIA — Population 600; surrounding area, 4,000. General practitioner needed. No other physician within 14 miles. Contact Merle Herr, Ulysses, Pennsylvania. Phone: 814-848-7572.

LETTERS TO THE JOURNAL

Second Injury Fund

Dear Doctor Davidson:

In the April 1966 JOURNAL there is a discussion of Second Injuries and Employment of the Handicapped. The bulk of the discussion is oriented to the worker who is handicapped by a previous industrial accident, the example given being that of a one-armed or one-legged worker who might lose a second limb.

However, the following statement is made: "The Second Injury Fund provides benefits for a worker who is totally and permanently disabled as the result of an industrial injury, if such person had previously been permanently and partially disabled from some other cause, irrespective of whether the previous injury or condition was industrial or non-industrial in origin."

The implication is that the pre-existing disability may be disability due to disease rather than the previous injury. However, I doubt that this is really the case. I would like clarification on this point, and I would particularly like to know whether, if it is indeed so, it is applicable to patients with convulsive disorder.

Yours truly,
Francis A. Wood, M.D.
Newark

Dear Doctor Davidson:

In reply to the question posed by Dr. Wood, the answer is that the pre-existing disability *may* be a disease rather than an injury and does not need to have any connection with employment. However, there are several major criteria. First, the disease must pre-exist the second injury. Second, the pre-existing disease must not have been totally disabling in itself. Third, the second injury must not have aggravated the pre-existing disease so that the total result is permanent disability. Thus, the patient with a "compulsive disorder" might be eligible for Second Injury Fund help if the convulsive state was not totally disabling prior to the second injury and if it was not aggravated to the extent of producing total permanent disability in combination with the second injury.

Sincerely yours,
Jarvis M. Smith, M.D.
Trenton

201st ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY

May 13-17, 1967
Haddon Hall, Atlantic City

Tentative Program

Friday, May 12, 1967

3:00 p.m. — Convention Office and Press Room Open
5:00 p.m. — Board of Trustees
7:00 p.m. — Board Buffet Dinner

Saturday, May 13, 1967

10:00 a.m. — Registration Opens
2:00 p.m. — Golden Merit Award Ceremony and Reception
4:00 p.m. — House of Delegates to be followed by MSP Discussion
7:00 p.m. — Officers Dinner
9:00 p.m. — Nominating Committee

Sunday, May 14, 1967

All Day — Installation of Exhibits
11:00 a.m. — Meetings of Reference Committees
2:30 p.m. — House of Delegates
6:00 p.m. — Reception for President-Elect

Monday, May 15, 1967

9:00 a.m. — Exhibits open
9:30 a.m. — Scientific Programs of MSNJ Sections
2:00 p.m. — Scientific Programs of MSNJ Sections
7:00 p.m. — Annual Dinner-Dance

Tuesday, May 16, 1967

9:30 a.m. — House of Delegates
9:30 a.m. — Special Scientific Programs of the Academy of Medicine/State Departments
1:00 p.m. — House of Delegates Luncheon
1:30 p.m. — House of Delegates Reconvenes
2:00 p.m. — Special Scientific Programs of the Academy of Medicine/State Departments
6:00 p.m. — Reception-Buffet Dinner for Tech. Exh.

Wednesday, May 17, 1967

9:00 a.m. — Board of Trustees
9:30 a.m. — Scientific Programs of MSNJ Sections
3:00 p.m. — Exhibits and Registration Close

ANNOUNCEMENTS

Course in Endocrine and Metabolic Disorders

The American College of Physicians announced a five-day graduate course, starting November 7, covering Endocrine and Metabolic Disorders. Covered will be the metabolic aspects of contraceptive agents, obesity, renal dialysis, and many other aspects of endocrinology and metabolism. For details, write to Dr. Stephen Donahue, American College of Physicians, 420 Lexington Avenue, New York, New York 10017.

Treatment of Drug Coma

Saturday morning, November 12, 1966, offers a chance to visit the beautiful, rolling hills of Hunterdon County and participate in a colloquium on the therapy of drug coma. Under the auspices of the sections on anesthesiology and internal medicine of the New Jersey Academy of Medicine, this program will take place at the Hunterdon Medical Center just north of Flemington, N.J. There is registration and a reception between 9:30 a.m. and 10. The program is set for the two-hour period starting at 10 a.m. Luncheon is free if you are a member of the Academy of Medicine. If not, the registration fee plus the luncheon can be covered at the modest overall cost of $5.

Obstetrics-Gynecology Symposium

A 4-day symposium on obstetrics and gynecology is scheduled for November 16 through 19 at the St. Barnabas Medical Center in Livingston. The subjects are: *Wednesday morning*: The Juvenile in Gynecology and Obstetrics. *Wednesday afternoon*: Reproduction. *Thursday morning*: The Breast. *Thursday afternoon*: Oncology. *Friday morning*: Cleft Palate, Electronics, Trophoblasts, Fluorochromes in Diagnosis, the Fetal Electrocardiogram and the Use of Computers. *Friday afternoon*: Geriatric Gynecology. *Saturday morning*: Radiation and Therapeutic X-ray. For more details, write to the Academy of Medicine at 317 Belleville Avenue, Bloomfield, New Jersey 07003.

The First Ten Days of Life

Although you may have passed them yourself, the first ten days of life present special hazards. Hear all about it at 5 p.m. Friday, November 18, at the Salem County Memorial Hospital in Salem, N.J. This is a joint program of the State Health Department and the New Jersey Academy of Medicine. A panel of distinguished physicians will lead the program.

Diabetes Mellitus

Hold the day before Thanksgiving Day for an afternoon seminar on diabetes. This meeting will be held from 2 to 5 p.m. at the Mountainside Hospital in Montclair, Wednesday, November 23. Supported by a Pfizer grant, this program is sponsored by the New Jersey Diabetes Association and the New Jersey Academy of Medicine. The meeting will concentrate on treatment.

Problems of Drug Abuse

The last day of November is set for a seminar on current problems in drug abuse. The meeting will be held at Roche Laboratories in Nutley, and is sponsored by Roche and by the Academy of Medicine of New Jersey. The program opens at 6:30 p.m., Wednesday, November 30. Registration fee is $4 except for Academy members (no charge for them). Selected speakers will lead discussion on narcotic addiction and L.S.D., with numerous related topics also in view.

Seminar on Cardiac Surgery

Friday evening November 18, at 8 p.m., is the time for a two-paper seminar on cardiac sur-

gery. Sponsored jointly by the New Jersey College of Chest Physicians and the Academy of Medicine, the program will be at the St. Barnabas Medical Center, Short Hills Road, Livingston. One paper by Charles Bailey, M.D., will be Revascularization of the Left Ventricle. The other — Ventricular Aids in the Failing Heart — is by Adrian Kantrowitz, M.D.

Venereal Disease in General Practice

At the Sandoz auditorium in Hanover, N.J. (State Highway 10 at Ridgedale Avenue) the Essex and Morris County Medical Societies, with an assist from Sandoz Pharmaceuticals, are sponsoring a program on venereal disease in general practice. This is on Thursday evening, December 1, at 8:30 p.m. The speaker is Martin M. Abbrecht, M.D.

Cancer Detection and the GP

On Thursday evening, January 26, under sponsorship of the Morris and Essex County Medical Societies, there will be a symposium on the role of the family doctor in cancer detection. This will be held in the Auditorium of the Sandoz Company, in Hanover, N.J. This is on State Highway Number 10, at Ridgedale Avenue. Sandoz Pharmaceuticals is a participant in planning and supporting the meeting. Principal speaker, Emerson Day, M.D., is director of the Strang Clinic.

Eye Conference

The ever-popular Wills Eye Annual Conference will be held February 9, 10 and 11, 1967 at the Bellevue-Stratford in Philadelphia. For details of this unique and practical symposium on ophthalmology, write to Dr. Albert Cleveland, 1601 Spring Garden Street, Philadelphia, Pennsylvania 19130.

Hypnosis Course

Starting March 1, 1967, an evening course in medical and dental hypnosis will be given at the Mountainside Hospital in Montclair. It starts on March 1, 1967 and will be held each Wednesday thereafter for 12 consecutive Wednesdays. The last meeting is scheduled for May 17, 1967. This is open to physicians and dentists only, and AGP credit will be given. For more information or for enrollment, write to Dr. Kenneth A. Bartlett at 460 Bloomfield Avenue in Montclair. This is sponsored by the N. J. Society for Clinical Hypnosis.

For Physicians in Industry

During the week of March 6, 1967, a special course will be given at the Columbia University-Presbyterian Hospital complex (Broadway at 168 Street, New York City) in industrial medicine. For details, write to E. R. Osterberg, M.D., School of Public Health, 21 Audubon Avenue, New York City, 10032.

New Booklet on Gout

You may obtain for your patients a new brochure on gout put out by the Arthritis Foundation. This is an up-to-date pamphlet discussing the drugs in use today, telling what we know about warding off an attack, and stressing the importance of working with the doctor in following medical orders. This twelve page pamphlet may be obtained by writing to the Arthritis Foundation, 1212 Avenue of Americas, New York 10036.

Rehabilitation Literature

Doctors and patients interested in the field of rehabilitation may want to subscribe to the journal, *Rehabilitation Literature,* published monthly by the National Society of Crippled Children and Adults, 2023 West Ogden Avenue, Chicago 60612. The subscription is $4.50 per year. In addition, an extensive library of free reprints of individual articles is available. The area covered includes not only the traditional area of rehabilitation in the field of orthopedic physiatry, but also includes material on blindness, mental retardation, and speech and hearing disorders.

Plastic Surgery

The American Academy of Facial and Reconstructive Surgery has made available an interesting pamphlet on plastic surgery, which

explains what is done in each of the common operations in a scientifically correct and prognostically helpful manner. You may obtain these pamphlets at $3.00 per hundred for free distribution to selected patients. The pamphlet is available at the office of J. R. Anderson, M.D., 1111 Tulane Avenue, New Orleans, Louisiana 70112.

Hodgkins Disease and Lymphocytic Leukemia

The National Cancer Institute is now studying lymphocytic leukemia and Hodgkins Disease. If you have such a patient, get in touch with The Clinical Center, Building 10, National Institute of Health, Bethesda, Maryland, 20014.

Blood Studies in Women Taking "The Pill"

New York University's School of Medicine is studying blood changes, if any, in women who have been taking contraceptive pills since 1964, or earlier. For details, write to Dr. Herbert Gershberg, Department of Medicine, 550 First Avenue, New York, New York 10016.

Your Role in Disaster Medicine

The AMA has made available a short pamphlet, "Role of the Physician in Disaster Medicine." It lists what you can do to help. It suggests how you can prepare a disaster medical kit for your own use. For your copy of this brief but useful brochure, write to Division of Social and Economic Activities, 535 North Dearborn Street, Chicago 60610.

The Role of the Rehabilitation Counselor

A new public affairs pamphlet, *Rehabilitation Counselor, Helper of the Handicapped,* is available for 25¢ from the Public Affairs Committee, 81 Park Avenue, New York, New York 10016. This spritely written pamphlet by Elizabeth Ogg, portraying the work of the rehabilitation counselor, will be helpful not only to patients needing such counselling, but also to young people considering this as a career.

OBITUARIES

Dr. Keith Kahn

Born in 1897, Keith Kahn received his M.D. degree at Vanderbilt in 1920. After his internship in New York City, he became interested in marine medicine and served the Port of New York, and later the American Export Lines. He was a ship's surgeon, making many trips in that capacity to many ports. Eventually he became Senior Surgeon to the line, retiring in 1956. Dr. Kahn then moved to West New York, and took part in numerous activities for our Hudson County Medical Society. He died on September 10, 1966 in the Dover General Hospital, at the age of 69.

Dr. Solomon Resnick

At the untimely age of 47, a heart attack took the life of Dr. Solomon Resnick on September 3, 1966. Dr. Resnick earned his M.D. at George Washington in 1943, and won one of the coveted internships at that university's hospital. He then did graduate work at Montefiore, at Harvard, and at the Lahey Clinic in Boston, and came to Jersey City in 1956 to devote himself to the private practice of gastro-enterology. Dr. Resnick was affiliated with the Jersey City Medical Center and with the Christ Hospital in that city.

Dr. Charles Yellin

At the early age of 53, Dr. Charles Yellin died of a coronary attack on August 24, 1966. Born in Brooklyn, he received his M.D. degree at Long Island in 1937. He came to the Elizabeth General Hospital for his internship, liked it in Union County, and had been serving the people of that county ever since. He was on foreign duty in the Army from 1943 to 1946. Dr. Yellin was especially interested in internal medicine and was, in that specialty, affiliated with both the Alexian Brothers and the Elizabeth General Hospitals. He served on the Board of Directors of the Union Heart Association.

BOOK REVIEWS

The Healing Art. Fred B. Rogers, M.D. and Arlene R. Sayre. Copyright 1966 by The Medical Society of New Jersey, Trenton. Pp. 346. Profusely illustrated. ($10).

The Medical Society of New Jersey is the oldest such society in the Western Hemisphere. The development of this volume was one of the features of our bicentennial celebration. It seems, to this editor, to be a great tribute to our organization and a valuable symbol of our proud heritage. The book is here reviewed by Dr. Samuel Berg, himself a medical historian of considerable standing. The views of Dr. Berg are, of course, only his own, and their publication here does not indicate that this JOURNAL or this Society concurs in these views.—Editor

The senior author of this book is Dr. Fred B. Rogers, a distinguished medical historian who has published many articles and three books on medical history. The co-author, Arlene R. Sayre, is a gifted writer in education and history.

The amount of material condensed in 340 pages of text is phenomenal. Just as Dr. Rogers' popular book, *Help Bringers: Versatile Physicians of New Jersey,* contains interesting material of a non-medical nature, so does *The Healing Art* contain many items of general historical significance. The reader will learn much about New Jersey—beginning 100 years before the founding of our Medical Society. One might regret that the authors had to eliminate interesting material because of space limitations, but we must express our gratitude to the officers of the Society for permitting a much larger publication than originally planned.

The book is impressive in general, disappointing in certain particulars. In using the index to spot-check some entries, I found that the reference to Martland Medical Center concerned merely an article published by three of its staff members, but no indication that the hospital was the only large general hospital to be named after a pathologist, and, notably, while still living. There is no reference to Newark Beth Israel Hospital, considered by many to offer one of the best internship-residency training experiences in New Jersey, nor any mention of its distinguished scientific journal, which is one of the best hospital-sponsored journals in the USA. Many will be disappointed in the omission of the names of the two founders of that hospital — Dr. Victor Parsonnet and Dr. Max Danzis, both major ornaments of our profession for many decades. It is astonishing to find St. Michael's Hospital completely ignored, though this institution was a true pioneer in cardiac surgery and in the development of graduate courses for physicians. The casual reference to Dr. Edwin Albano is disappointing, too. The classic-paper on lymphoma-leukemia interrelationships by Dr. William Bernhart is also passed over; indeed, there is no reference to this distinguished internist and hematologist anywhere in the book. One of the earliest — and certainly the longest-lived—medical radio programs in the country, the work of Dr. Victor Knapp, is also forgotten in these pages.

Other society members will be disconcerted by omissions of items which they consider significant. These are less a reflection on the authors than on the officers of the county societies, who failed to submit material pertaining to local medical activities, as requested.

Several errors were found, only one of which is heartbreaking. Dr. William D. Crecca misses immortality on page 267 and in the index by being mis-spelled Creece.

In our judgment, this is by far the best book on the history of medicine in New Jersey in text and illustrations and elegant craftsmanship. It will make an unexcelled gift for all physicians, future physicians, paramedical personnel, and anyone entertaining the slightest interest in the healing art. SAMUEL BERG, M.D.

Sex and the College Student. Group for the Advancement of Psychiatry. New York, 1966, Atheneum Press. Paperback. Pp. 168. ($2.45)

"Sexual activity privately practiced," says the Committee which authored this book, "should not be the concern of the college administration." This includes "private homosexual behavior," too. It is suggested that colleges should furnish factual information on contraception. If it wants to avoid sanctioning sexual activities, the university would not have to dispense contraceptive equipment, too. The Committee pleads for a clear policy by the college administration, so that the students may know exactly what the college will tolerate and what it won't. The apparent increase in sexual activity at the college student level is ascribed to several causes. The first two listed are "the broad impact of psychoanalytic theory" and "the findings of the Kinsey report."

The report concludes with an appendix which outlines psychosexual development as interpreted by psychoanalytic theory. The book, in general, is a serious report on a matter of major interest, an attempt to suggest some guidelines, and a sophisticated, but not polemic, brief for more comfortable acceptance of greater sexual freedom on the campus.

VICTOR HUBERMAN, M.D.

Spontaneous Regression of Cancer. Tilden C. Everson, M.D. and Warren H. Cole, M.D. Saunders, 1966, Philadelphia. Pp. 560. Illustrated. ($20.00)

This is a compilation of 182 cases of malignant disease in humans confirmed by histopathology, in which a partial or complete, temporary or permanent regression of the tumor occured in the absence of therapy sufficient to produce this result. These are instances of tumor-host relationship in which the host predominated; however, the end result was not necessarily a spontaneous cure.

The area of human tumor-host relationship is one of vast ignorance due to the relative infrequency of a situation in which a patient can ethically be studied without being treated. Yet, here is an area of great importance in the evaluation of therapy. This book brings a ray of light into the void, but must be considered a preliminary step. The authors, both distinguished scientists, have had a long and serious interest in the subject and have compiled information that is meaningful to anyone involved in the development and testing of therapy for use against malignancy in humans. The cases point up the possibility of host factors in the regression of tumors. On the other hand, the end results show the small chance of spontaneous cure. Evaluation of permanent regression is difficult due to the short time between the observed regression

and the report in many of the cases. However, 16 of the patients are known to have ultimately died with malignancy.

The purpose of the book is to bring to the attention of investigators and others the existence of this biologic phenomenon by presentation of case histories. This is well done with a minimum of editorialization and a maximum of selection and critical detachment. Each chapter is devoted to an organ or region and is opened with a brief report on life expectancy for untreated patients with this tumor, and also a statement as to the current therapy. The chapters close with a summary of the case, brief speculation as to the causes of the phenomenon, and bibliography. Tumors are: carcinoma of the kidney, 33; neuroblastoma, 29; malignant melanoma, 19; choriocarcinoma, 19; urinary bladder, 13; sarcoma of soft tissue, 11; sarcoma of bone, 8; colon and rectum, 8; testis, 8; ovary, 7; breast, 6; primary site unknown, 4; uterus, 4; stomach, 4; liver, 2; lung, 2; thyroid, 2; and larynx, pancreas, and tongue, one each.

The numerous illustrations of patients, x-rays, and histopathology are of good quality. The book is usefully indexed.

ALLAN LAZAR, M.D.

The Merck Manual. Rahway, N. J., 1966, Published by Merck & Co. Pp. 1848 with more than 800 prescriptions and numerous tables. Thumb-indexed ($7.50)

Not long ago, at a Congressional hearing, a witness used the well known *Merck Manual* to validate a point he was making on the cause of a disease. Since it first appeared in 1899, countless medical students have found it a valuable *vade mecum*. While the presentation of any one disorder may be too concise for the specialist, the book a a whole is a gold-mine for the specialist in other fields. Here the otologist can get a run-down on megacolon, while the gastro-enterologist can learn about tuberculous laryngitis.

Tables, charts, and illustrations enliven and simplify the text. While preoperative and postoperative routines are well described, surgical procedures are not detailed. Generous cross-reference citations increase the usefulness of the text. Main emphasis is on diagnosis and treatment, but there is enough material on physiology and pathology to add a scholarly dimension to the doctor's understanding of a disorder outside his accustomed field of practice. All in all, *Merck's Manual* 1966 continues to be relevant, reliable, and readable.

HENRY A. DAVIDSON, M.D.

Disorders of Carbohydrate Metabolism in Infancy. M. Cornblath, M.D. and R. Schwartz, M.D. Philadelphia, 1966, Saunders. Pp. 297. ($8.50)

This book is the third in the series of "major problems in clinical pediatrics" designed to give an exhaustive and up-to-date view and review of problems we are likely to encounter among our own patients or as consultants to other physicians. In this volume, the writing is clear; the contents not too superficial and yet not too deep, but just right. Though practical aspects of diagnosis and management are treated exhaustively, basic understanding is stressed and theory treated just enough to make it interesting.

The first part of the text deals with the basic metabolism of carbohydrate and the homeostatic metabolic adjustments in pregnancy and the neonate (full term and low birth weight). The other sections discuss problems of the neonate (infant of the diabetic mother, transient symptomatic neonatal hypoglycemia, transient diabetes mellitus), hereditary metabolic disorders (disorders of glycogen metabolism, galactose and fructose intolerance), hypoglycemic syndromes in infancy, and sugar malabsorption syndromes. The appendices contain diets free of galactose, sucrose, fructose, leucine, and starch, and also the carbohydrate content of foods broken down into monosaccharides, disaccharides, and polysaccharides.

Definitive diagnosis of many carbohydrate disorders would be difficult in the average community hospital; e.g., enzyme biochemical analyses of biopsied muscle and liver, peroral biopsy of intestinal mucosa would not be available in most hospitals. A thorough history and physical examination, performance of as many laboratory tests as the hospital can perform with accurate results, and then referral of the patient to a medical center equipped to carry out *all* the tests necessary would be the way the patient should be handled. It is not the intent of the authors of this book to have the patient cared for otherwise, but they do stress an early diagnosis and rapid treatment lest irreparable damage (especially in hypoglycemia) occurs to the brain. Emergency treatment for hypoglycemia can be started even before a definitive diagnosis of carbohydrate intolerance is made.

It would be impossible for the pediatrician to obtain, on his own, all the material in this book. It comes as a welcome relief to have authorities such as these authors weed out the unnecessary literature and condense the up-to-date knowledge of carbohydrate metabolism in the newborn and infant. Cornblath and Schwartz are to be praised for this work. Pediatricians, pediatric residents, and all physicians interested in metabolism should read this book .

MILTON PRYSTOWSKY, M.D.

Early Management of Acute Trauma. Edited by A. M. Nahum, M.D. St. Louis, 1966, Mosby. Pp. 336 with 271 illustrations ($21.00)

While many diseases have come under control in the last half century, accidental injury remains as an increasing threat. Any doctor, no matter in what specialty, may have to come to the rescue in the immediate post-traumatic period. Here Dr. Nahum and his 22 contributors have compressed an enormous amount of useful information on what to do until the specialist comes. There are chapters on shock, on abdominal injuries, on accidents suffered on playing fields and in athletic arenas. There is a guide to the management of injuries to the eye, the face, and the jaws. Among children, one third of all deaths are of traumatic origin; and here is a noteworthy chapter on the immediate management of injuries among children and infants. Head and spinal injury get — and need — special chapters. Although "heart attacks" are not usually classed as "traumatic," the book includes a usable chapter on cardiac arrest. There is material here on blood transfusions, on radiologic aids to rapid diagnosis, on chemotherapy, on injuries to the skull and to the extremities, and on chest injuries. And, as a bonus, there is a unique chapter on handling the anxiety and other emotional problems involved in managing the victim of injury — and his relatives. This handy volume will soon earn its space on the shelf of any clinic, emergency room, or doctor's office.

ULYSSES S. FRANK, M.D.

Arteriography: Principles and Techniques. Joseph L. Curry, M.D. and Willard J. Howland, M.D. Saunders, 1966, Philadelphia. Pp. 328. Illustrated ($14.00)

The authors have achieved their aim in offering an introduction to aortography and arteriography. They explain in almost "cook book" detail how they perform the various angiographic and catheter procedures in their community hospital practice. In their enthusiasm for these studies, they do not neglect to detail the hazards and precautions which these studies entail. This book should be especially appealing to the radiologist in the community hospital away from the large teaching centers. It will also be useful to those older radiologists trained prior to the availability of arteriography. It offers the student, intern, and resident some familiarity with these studies which involve almost every branch of medicine.

This volume is an introduction. The hundreds of articles written annually on the details of these studies are readily available to the experienced arteriographer. This book includes numerous excellent diagrams and illustrations. Reproduction of the radiographs is good.

The large experience of the authors demonstrates that these procedures can safely and satisfactorily be carried out in a community hospital practice. The book deserves a place in every hospital's library and x-ray department. JAMES J. STOVIN, M.D.

The Pediatrician's Ophthalmology. A collaborative effort of several authors. Edited by Sumner D. Liebman, M.D. and Sidney S. Gellis, M.D. St. Louis, 1966, C. V. Mosby Company. Pp. 352 ($19.50)

If for no other reason than to familiarize the pediatrician with ophthalmologic terminology, this book is valuable. Its value, however, does not stop there. The text clarifies the common eye conditions encountered by the pediatrician and disposes of scientific myths grown up over the years about the development of the eye and its function.

The volume seems to conform to a logical plan, going from anatomy to growth and development to methods of examination and winding up with genetics, social aspects, emotional factors, and reading disability.

Eye defects and diseases seen in pediatricians' offices are usually referred to the ophthalmologist. This is as it should be, if we are to prevent many cases of amblyopia ex anopsia. The ophthalmologist sends a report to the pediatrician, who then discusses it with the mother. The pediatrician who reads this clear text will be in a better position to do this and also to have time by not having to call the ophthalmologist and discuss the meaning of his letter.

The essays are clearly and concisely written and accompanied by many diagrams, illustrations, and photographs which give it a "do it yourself quality." Advice about specific therapy is generous. This is especially true about the pediatrician's role in screening for errors of refraction, followed by a discussion of the value of various methods of correction, such as glasses, exercise (orthoptics), and drugs.

The best essays are the discussions of strabismus, errors of refraction, and external diseases of the eye, all three of which are dealt with frequently in the pediatrician's office. Emphasis is on methods of handling strabismus and a description of patching, glasses, drugs, and exercise, and when to use each or any of these.

The chapter on external diseases of the eye includes a careful and explicit naming and explanation of the various diseases and defects, such as infections, trauma, congenital defects, deformations, and foreign bodies. The pediatrician here learns how to deal with them. There is a detailed explanation of the proper pediatric examination of the eye describing the aids, instruments and lights that are necessary. Of great use to the non-ophthalmologist is the simple but detailed explanation of the development of fusion, accommodation, and stereopsis.

Congenital cataracts and acquired cataracts are dealt with in great detail by Dr. Cordes. This is one of the best essays. It includes many illustrations, schemata, and photographs of afflicted eyes. This discussion has great appropriateness now that cataracts have assumed a greater importance since the discovery of its connection to prenatal German measles. Most disappointing is the discussion of reading disabilities.

Other discussions include genetics (and here it would be helpful to understand chromosonic karyotypes), the ocular manifestations of the systemic diseases, glaucoma, and neuro-ophthalmology in children.

Although all phases of pediatric ophthalmology are presented, it is by no means a complete textbook and is not meant to be. It is an excellent, practical, and well-illustrated guidebook. RALPH N. SHAPIRO, M.D.

Radiographic Atlas of The Genitourinary System. Charles Ney, M.D. and Richard M. Friedenberg, M.D. Lippincott, 1966, Philadelphia. Pp. 741 with 1,661 illustrations. ($36.00)

This x-ray atlas is excellent in its method of preparation and organization of subjects. The organization of normal and pathologic states, each preceded by a summary of the total picture, is most welcome for daily reference for diagnosis. The authors caution against depending on excretory urography as a renal function test. Examples of errors that this can lead to are illustrated by retrograde pyelograms.

The x-ray photographs are good on the whole, although in some, a magnifying glass is needed to view the fine points explained in the footnotes. This superb atlas is valuable to the internist and general practitioner as well as a necessity for the library of the urologist. EDWARD PHILLIPS LEVINE, M.D.

Current Therapy 1966. Edited by Howard Conn, M.D. Philadelphia, 1966, Saunders. Pp. 857. ($13.00)

In this hefty volume, a galaxy of specialists tell us what their favorite treatment method is. While medication is not the only modality described here, the bulk of the regimes presented do use drugs. Unfortunately, the various authors are inconsistent about the use of generic names. Thus, Roger Mitchell recommends chlordiazepoxide, while D. W. Baxter prefers Librium (the same drug). The book covers almost everything in common medical practice. The text is further enriched by a tabulation of normal laboratory values conveniently placed in the end-papers. This volume will surely soon earn its keep on any practitioner's reference shelf. ULYSSES FRANK, M.D.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

NOVEMBER, 1966 • VOL. XXXIX, NO. 9

PULMONARY EMBOLISM IN HEALTHY PEOPLE

Deaths due to massive pulmonary embolism in ambulant people were found on a number of post-mortem records. Non-fatal cases were observed clinically. Early diagnosis is important so that anticoagulant therapy may be started at once. Radioactive scanning also shows promise.

Until a few years ago the occurrence of major pulmonary emboli in ambulant healthy people had received little general recognition, but in recent years there have been increasingly frequent reports of this condition.

However, many clinicians still fail to recognize the condition and make a diagnosis of pulmonary embolism only in the post-operative case, the case in gross heart failure, in the bedridden, or in the aged.

Several instances of clinical diagnosis of this condition have raised the question of whether there were not a number of patients who died either before diagnosis or before treatment could be effectively instituted. A study was therefore made on the basis of necropsy records of fatal cases and of cases diagnosed and treated in life.

Records of 27 fatal cases were studied. Of these, nine occurred outside the hospital and 18 following admission to the hospital. The age range was 23 to 69 years; six were men and 21 were women.

In all cases either a large embolus straddled the pulmonary artery bifurcation or both main pulmonary arteries were blocked by thrombus. In most cases an earlier thrombus was also present in peripheral branches with or without infarction.

Venous thrombosis was demonstrated at necropsy in all but one case—in deep veins of the leg in 16, uterine veins in 3, pelvic veins in 3, and superficial and deep veins in 4.

Two patients were five months pregnant, and one was eight days post partum and had previously been toxemic.

In six cases there was evidence of venous thrombosis at the time of hospital admission. In two cases venous thrombosis became evident after admission. The initial hospital diagnosis varied widely — pulmonary embolism in 3, pneumonia in 6, coronary thrombosis in one, deep-vein thrombosis in 3, cerebral vascular accident in one, gastro-intestinal hemorrhage in one, pulmonary hypertensive heart failure in one, secondary carcinoma of lung in one, and in one it was uncertain.

The duration of symptoms varied from a few hours to five months. Two cases followed ligation of varicose veins — one at five days and one at two weeks.

Clinical Diagnosis

In the part of the study relating to diagnosis in patients treated in life, 39 cases of major pulmonary embolism were reviewed. Diagnosis was made on the basis of history and physical signs, often with confirmation from the electrocardiogram or chest X-ray films.

Fifteen cases were related in time to preg-

H. A. Fleming, M.D., and Sheila M. Bailey, M.B. *British Medical Journal,* May 28, 1966.

nancy. Twenty-four (62 per cent) had a history or clinical evidence of venous thrombosis, though in five this did not become evident until after the embolus had been diagnosed. Two had severe varicose veins without evidence of thrombosis. Seventeen patients (43 per cent) were overweight.

Symptoms Varied

Symptoms, which began from a few hours to seven years before diagnosis, were: chest pain in 19, dyspnea in 15, faintness in 12, and fatigue in 5. All were treated with anticoagulants and made a good recovery.

The electrocardiogram was normal and remained so in 11 cases, but showed some abnormality in 28. Several studies indicate that possibly not more than 20 per cent of patients who subsequently have pulmonary embolism develop any electrocardiographic changes, and of these a still smaller number show identifiable diagnostic abnormalities.

Chest X-ray films were seldom diagnostic. Clinicians and radiologists are still liable to expect opacities in the lung field rather than the paucity of vascular markings on the affected side, which is more usual when embolus without infarction has occurred. An appearance of plethora on the normal side may also be observed. Dilatation of the main pulmonary artery and of the right heart are again signs of advanced disease and are not helpful for early diagnosis.

Pulmonary angiography can be diagnostic and is essential before embolectomy is considered. However, it is not without risk in the gravely ill patient and, again, it is not likely to be used routinely to confirm the diagnosis in a healthy patient who has just had one clinically suspicious episode.

Respiratory function studies have a useful purpose in confirming a disturbance of ventilation perfusion ratios. However, the technics are not easy and the procedure may be difficult in the ill patient. These technics undoubtedly have their place, but their reliability is not yet established.

Serum enzymes may be suggestive. It has been reported that elevation of the serum lactic dehydrogenase activity, an increase in the serum bilirubin concentration, and a normal serum glutamic oxalacetic transaminase activity are diagnostically helpful. However, these results may be mimicked by other conditions.

Radioscans Helpful

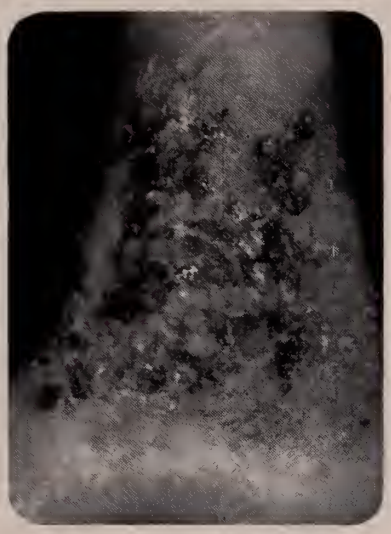
Scanning of the lung fields after the injection of macro-aggregated radioiodinated serum human albumin appears to be the most hopeful early diagnostic test. This radioactive material is held in the small pulmonary vessels and does not enter those blocked by embolus. It appears to be an accurate and simple method of locating areas of pulmonary arterial block. There would be no particular difficulty about carrying this out in the early case that may have a recurrence of symptoms while on anticoagulants, or in the seriously ill patient.

As for prognosis, in simple major pulmonary embolus there appear to be three possible courses. The most common is that the condition clears completely and there is no recurrence. However, the first embolus may be followed rapidly by others, leading to the classical advanced picture of massive pulmonary embolus, which is often fatal. The third possibility is that further emboli are so distributed in time and space that with or without major episodes there is a gradual development of thromboembolic pulmonary hypertension. Early diagnosis and treatment are essential if this is to be avoided.

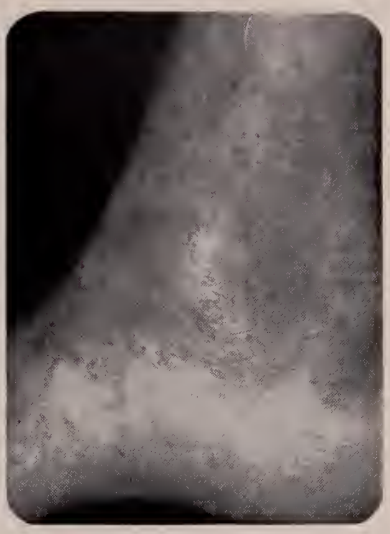
Diagnosis must be made at the earliest possible time and treatment with anticoagulants instituted. In the first instance full doses of heparin must be used. If anticoagulant therapy is pushed firmly, surgery to the veins or embolectomy will not commonly be necessary.

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against the usual gram-negative urinary pathogens

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This clinical study shows that the two combinations of antibiotics were not superior to some of their single components. The authors point out that antibiotic antagonism often negates theoretical advantages of multiple therapy. Coly-Mycin Injectable (colistimethate sodium) was one of the single components that was shown to be equal to the combinations and eradicated bacteriuria in two-thirds of the patients.

Theoretical choice of multiple antibacterial therapy has been shown to be no more effective than one well-chosen agent which also offers least patient exposure to possible side reactions, toxicities, allergic manifestations and higher drug costs.

1. McCabe, W. R., and Jackson, G. G.: New England J. Med. 272:1037, 1965.

in gram-negative urinary tract infections often the single well-chosen agent



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Indications: Especially indicated for the treatment of severe acute and resistant chronic urinary tract infections due to sensitive strains of gram-negative organisms. Also indicated in respiratory tract, surgical, wound and burn infections and in septicemia due to sensitive organisms. Particularly indicated when any of these infections are caused by sensitive strains of *Pseudomonas aeruginosa.*

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Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectable (colistimethate sodium).

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Warning
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Use with caution in the first trimester of pregnancy.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made to guard against blood dyscrasias.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. Moderately lowered red cell count may sometimes occur due to hemodilution. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vertigo or languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects.

Confusional states, hyperglycemia, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

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Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability, or excitement may be encountered.

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*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

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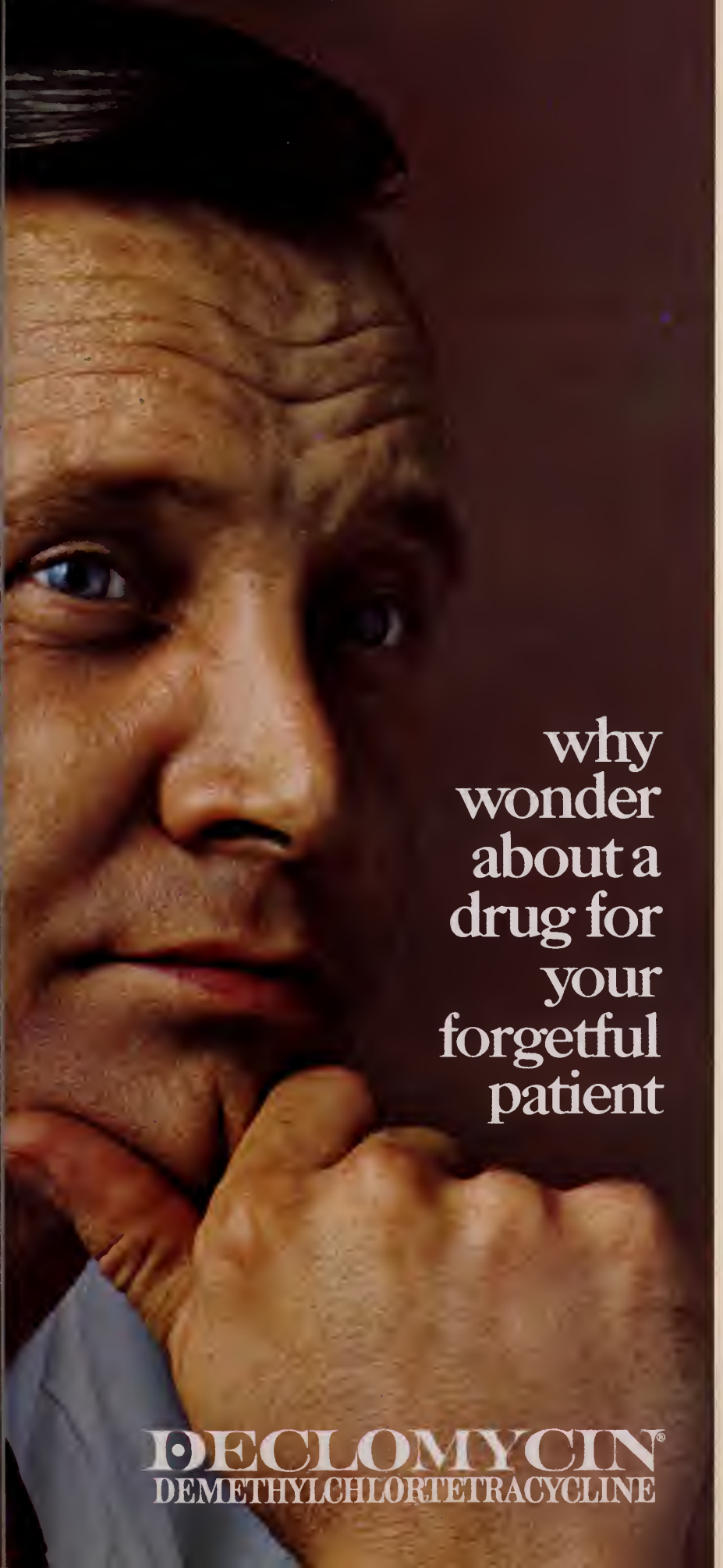


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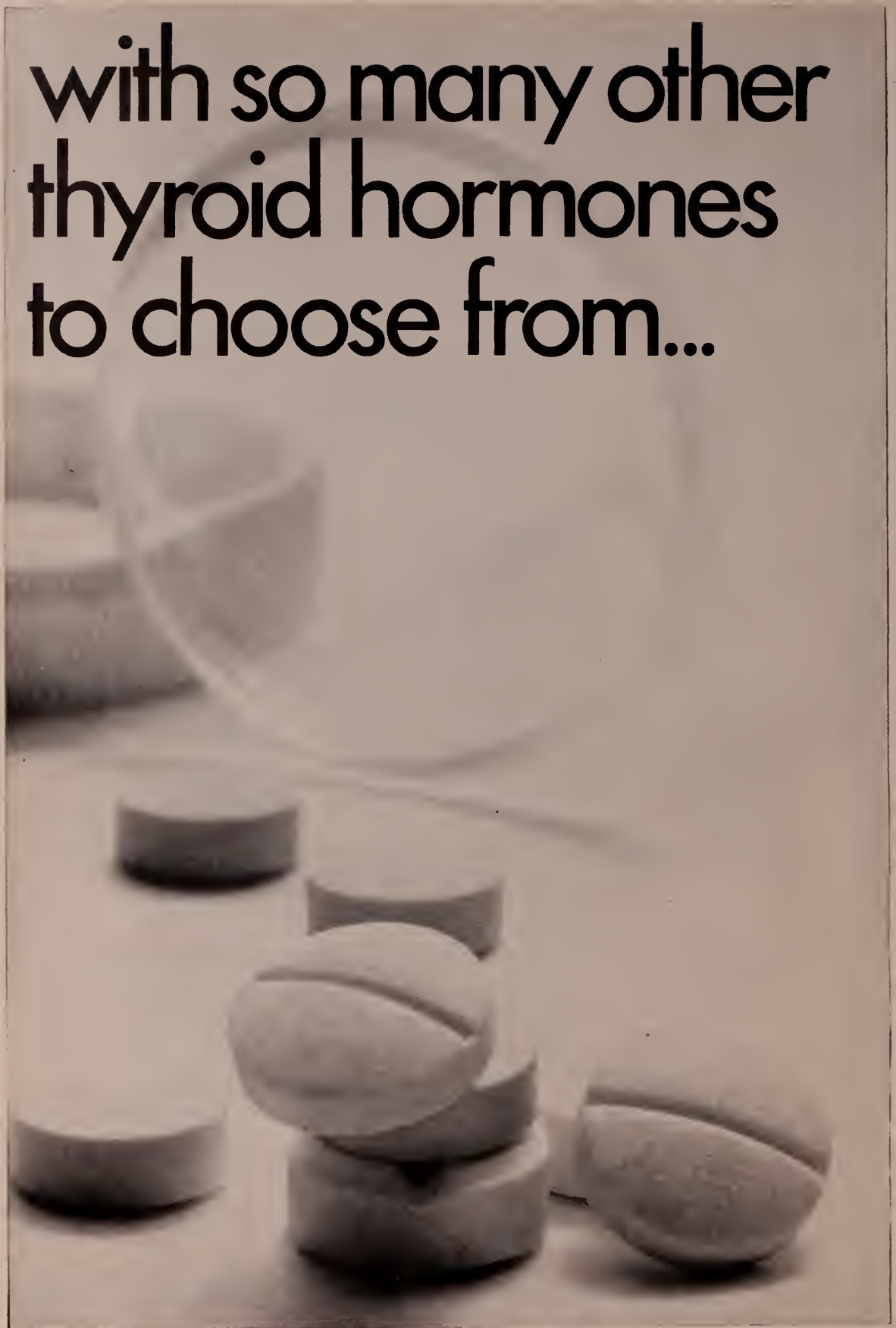
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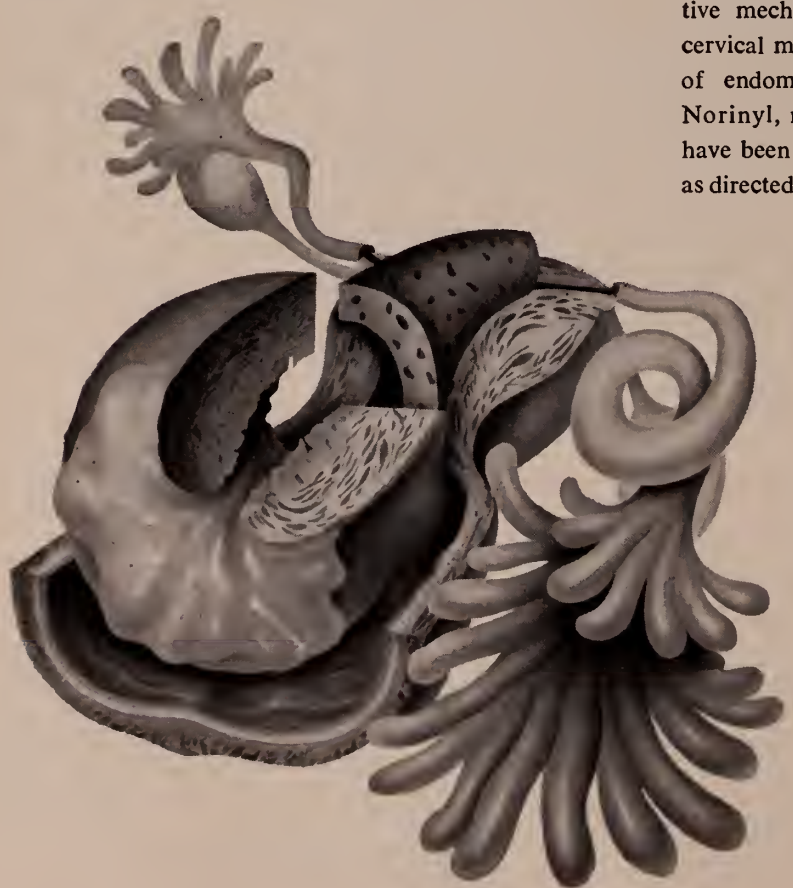
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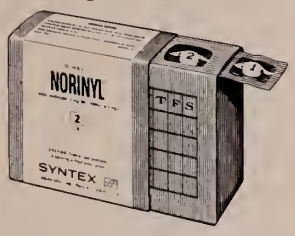
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Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.
Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.
Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.
NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.
Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)
Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Brvans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

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References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

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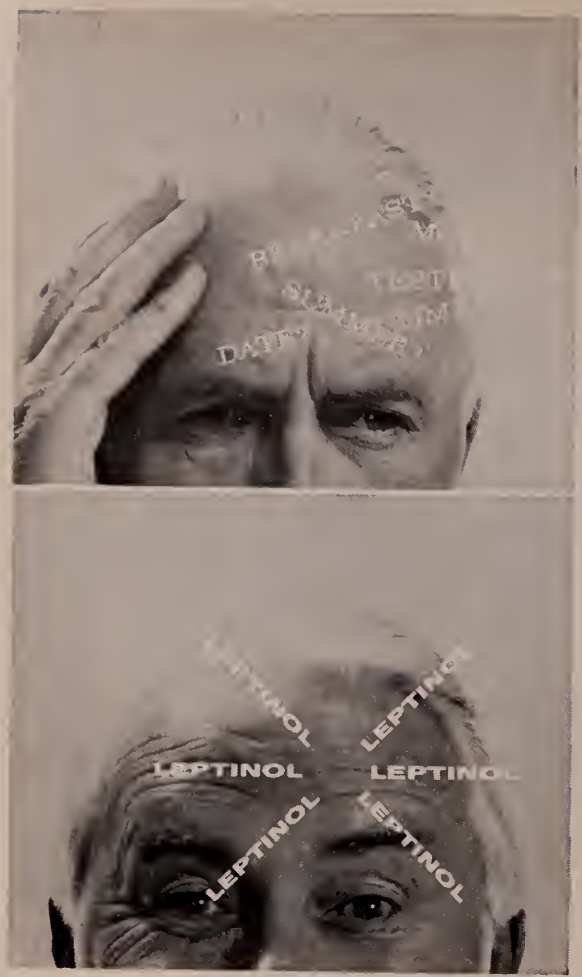
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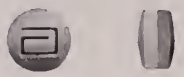
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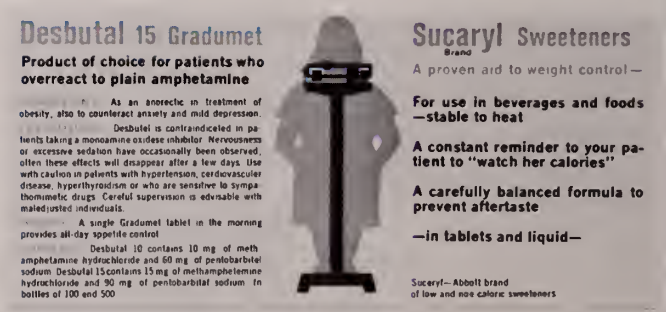


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"'Tranquilizer' is not a good word"[1]

"THIS classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."[2]

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary[3] a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference[4] lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there are differences in their actions — and in their effects. They have been divided into three categories — the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.[5]

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.[5]

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.[5]

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.[1] This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more severely disturbed. This is not necessarily true.

The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."[6]

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.[7] Also under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Fluphenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.[7]

RELATIVE SEDATIVE AND ANGOLYTIC INDICES OF PRINCIPAL PHENDTHIAZINES*

DRUG	SEDATIVE INDEX	ANGOLYTIC INDEX	BASED ON STANDARD DOSE OF
Chlorpromazine	100	15	25 mgs.
Triflupromazine	100	15	25 mgs.
Thioridazine	90	17	25 mgs.
Perphenazine	15	25	4 mgs.
Carphenazine	25	25	25 mgs.
Trifluoperazine	3.3	95	2.0 mgs.
Fluphenazine	3.5	100	2.5 mgs.

*adapted from Sainz[7]

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Precautions: Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

Side Effects: Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry mouth, abnormal lactation, polyuria, hypotension, and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

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References: 1. Simpson, G.M.: Postgrad. Med. 39:557, 1966. 2. Freyhan, F.A.: Am. J. Psychiat. 115:577, 1959. 3. Dorland's Illustrated Medical Dictionary, ed. 24, Philadelphia, W. B. Saunders Co., 1965, p. 1603. 4. Physicians' Desk Reference, 1966, Oradell, N.J., 1965, p. 310. 5. Cohen, S.: Northwest Med.: 65:197, 1966. 6. Detre, T., and Jarecki, H.: Connecticut Med. 25:553, 1961. 7. Sainz, A.: Psychosomatics 5:167, 1964.

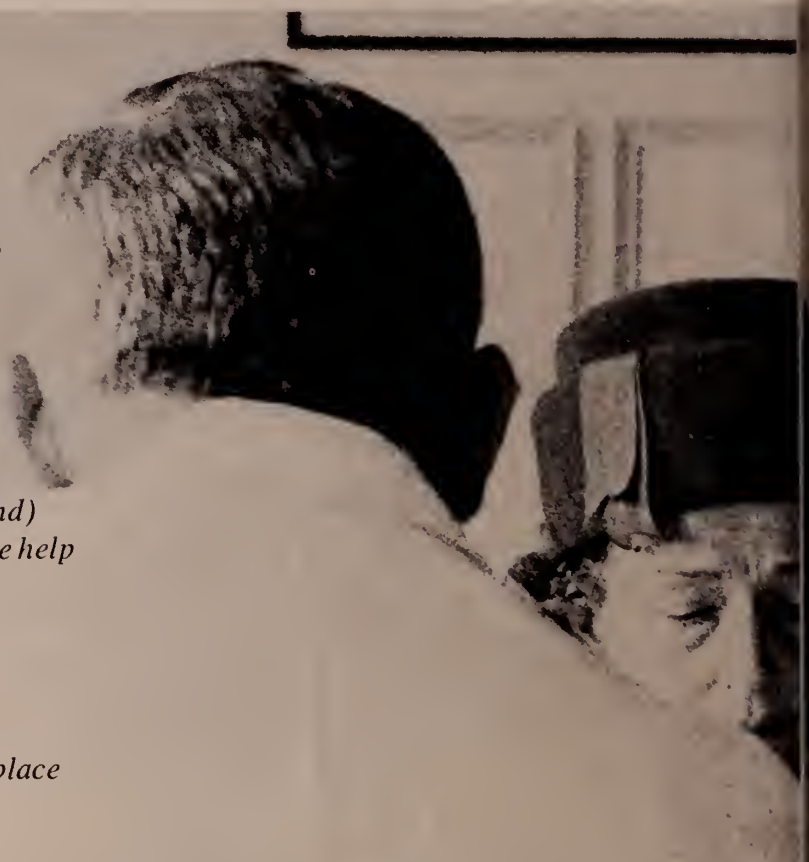
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CONTENTS • Pages 543 to 578

EDITORIALS
- The Physician and the Icarus Syndrome 543
- Confidential Communication 544
- Daniel F. Featherston, M.D., 1896-1966 544

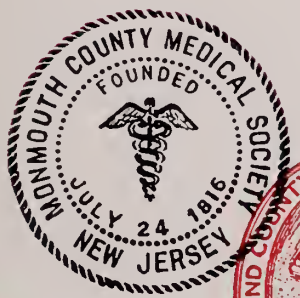
ORIGINAL ARTICLES
- Diagnosis and Treatment of Renal Insufficiency
  Norman Lasker, M.D., Hillside 545
- Asthma Complicated by Bronchial Foreign Body
  Elmer N. Mattioli, M.D., Vineland 551
- Resuscitation of Depressed Newborns
  Bradley E. Smith, M.D. and Frank Moya, M.D., Miami, Florida 552
- Cigarette Smoking in Children
  Paul H. Steel, M.D., Atlantic City 555
- Rehabilitation of the Disabled Worker
  Jarvis Smith, M.D., Trenton 558

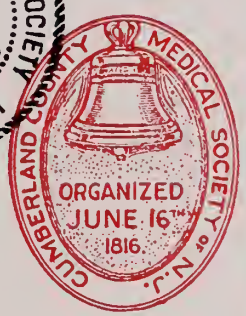
STATE ACTIVITIES
- Hypnosis Course 550
- Academy of Medicine Meetings 554
- Trustees' Minutes: October 16, 1966 561
- Academy of Medicine Acquisitions 565
- Annual Meeting—Tentative Program 567

OBITUARIES 568
BOOK REVIEWS 569
ANNUAL INDEX 1966 571
RESPIRATORY DISEASES ABSTRACTS 577

December 1966 • Vol. 63, No. 12

INDEX ISSUE











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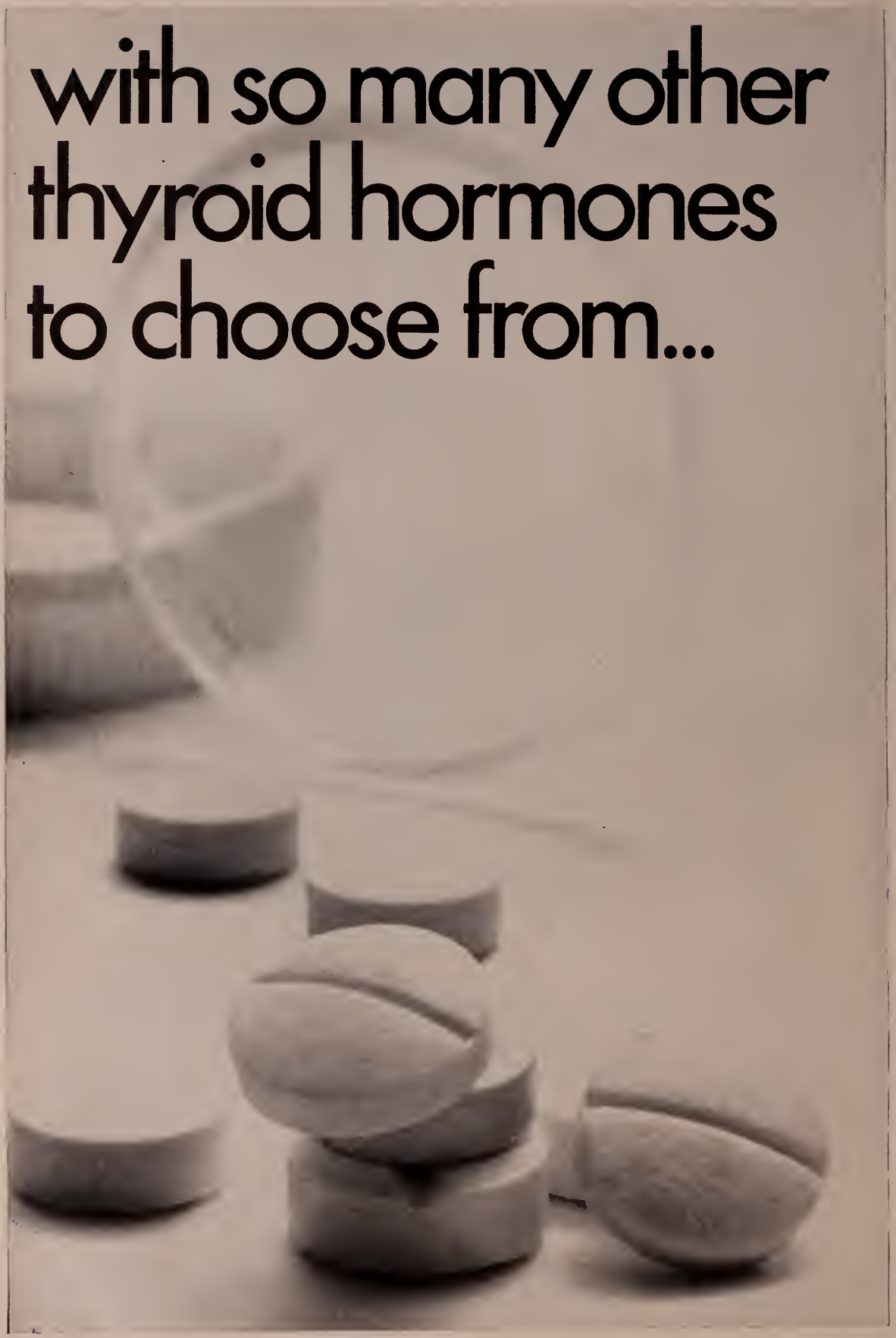
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Precautions: As with other thyroid preparations, an overdose may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. Medication, in such cases, should be stopped for 2-6 days, then resumed at a lower dose level. In patients with diabetes mellitus, careful observations should be made for changes in parameters that are used to guide antidiabetic therapy. **Contraindications:** Thyrotoxicosis, acute myocardial infarction. **Administration and Dosage:** Administer tablets as a single daily dose, preferably after breakfast. Injection may be administered intravenously in solutions containing 100 mcg. per ml. **Supplied:** Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., scored and color-coded, in bottles of 100 and 500. Injection: 500 mcg., lyophilized, in 10 ml. single dose vial, with 5 ml. vial of diluent.

EASY TO PRESCRIBE—EASY TO USE

0.1 mg. SYNTHROID (sodium levothyroxine)
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B and C vitamins are part of therapy: An imbalance of water-soluble vitamins and chronic illness often go hand in hand. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, are formulated to meet the increased metabolic demands of patients with physiologic stress. In chronic illness, as with many stress conditions, STRESSCAPS vitamins are therapy.



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Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
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Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

In sinusitis, colds, or U.R.I., Dimetapp lets congested patients breathe easy again. Each Extentab brings welcome relief all day or all night, usually without drowsiness or overstimulation. Its key to success? The Dimetapp formula—Dimetane (brompheniramine maleate), a potent antihistamine reported in one study to have elicited side effects as few as the placebo,* teamed with decongestants phenylephrine and phenylpropanolamine—in a dependable 10- to 12-hour form.

*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

Contraindications: Patients hypersensitive to antihistamines. Not recommended for use during pregnancy.

Precautions: Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability, or excitement may be encountered.

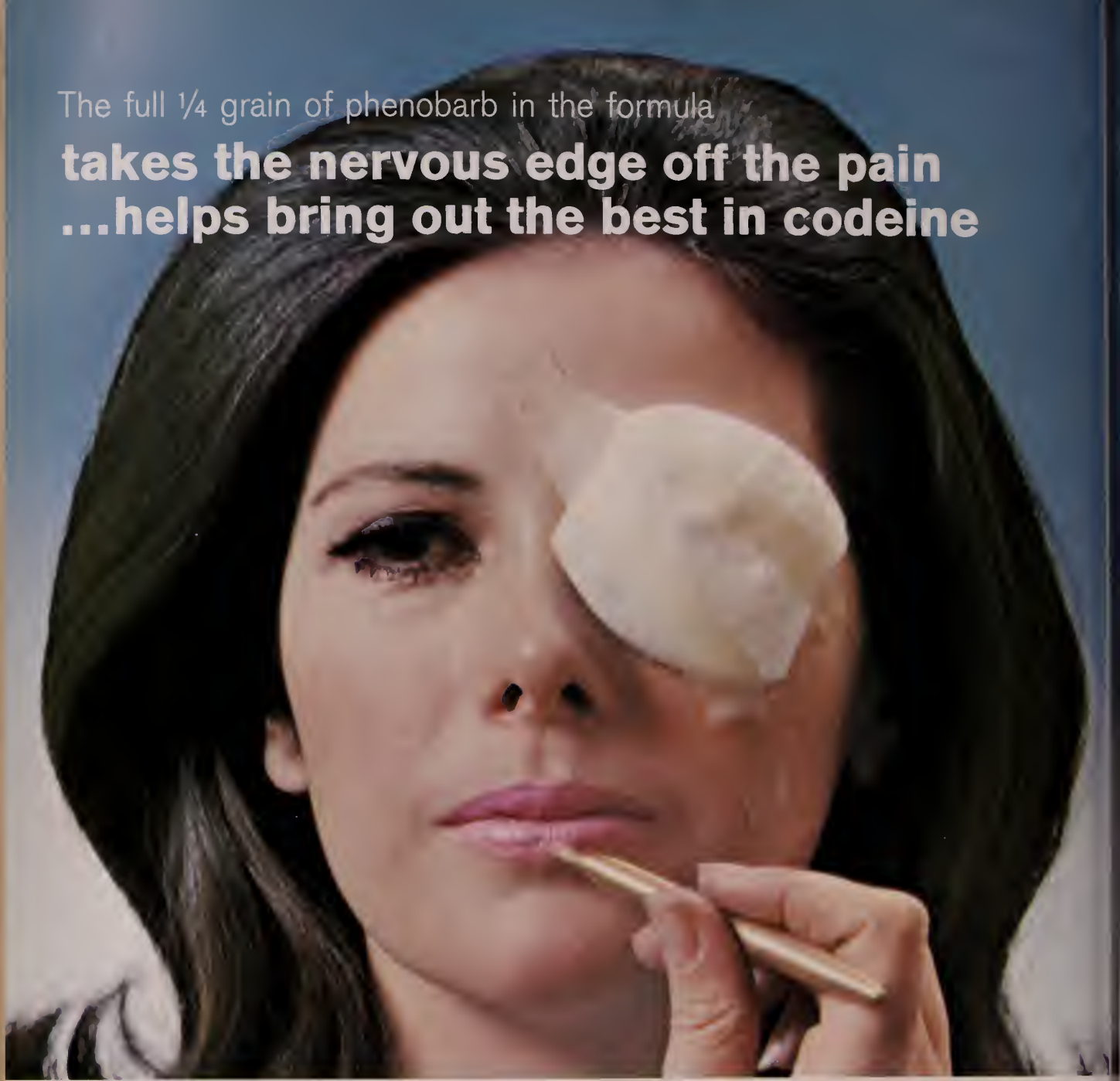
Dosage: 1 Extentab morning and evening, or as needed.

Supplied: Bottles of 100 and 500.

Also available: Dimetapp® Elixir for conventional *t.i.d.* or *q.i.d.* dosage. See package insert for further details.

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takes the nervous edge off the pain ...helps bring out the best in codeine

Phenaphen® with Codeine

the only leading compound analgesic that calms instead of caffeinates

Each capsule contains:

Phenobarbital (¼ gr.) ..... 16.2 mg.
(Warning: may be habit forming)
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Codeine phosphate.....¼ gr. (No. 2), ½ gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)

Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon—nausea, constipation, and drowsiness have been reported.

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And then diet. Diet. Diet.

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As a professional you can help wrest some sense from this nonsense: first, by cautioning against skipping meals, and second by pointing the way to realistic weight control through nourishing meals every day. Day after day.

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Project Weight Watch has been initiated to assist you. Its scope is nationwide, its purpose is to focus professional attention on the problem.

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We believe a strong Blue Shield is medicine's strongest bulwark against further infringements upon its freedoms of practice, and one of America's best hopes for the future of a free society. We're working toward that. Are you helping?

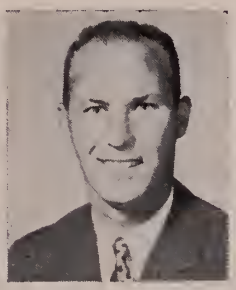
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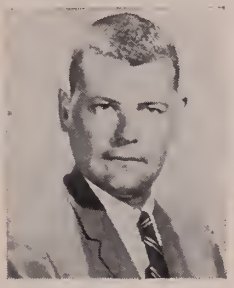
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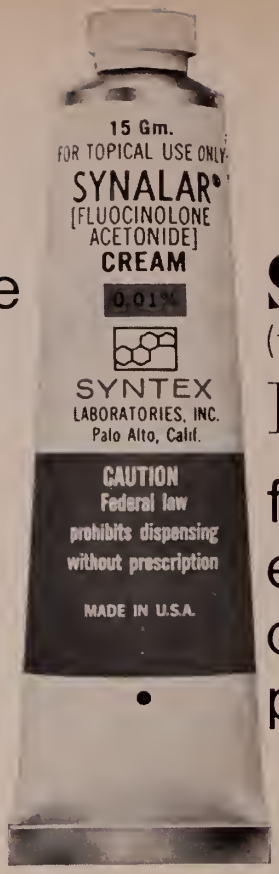
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Synalar® 0.01

(fluocinolone acetonide) cream

15 Gm.

for even greater economy in office or hospital practice

the superiority topical with the

Now you can prescribe as little or as much Synalar Cream 0.01% as is needed for a particular therapeutic problem in a size that permits the greatest economy for your patient. The new 15 Gm. tube, for example, is best suited for short-term therapy and for small sites. For more extensive body areas prescribe the 45 Gm. tube—a size that's also ideal for your treatment table. And the 120 Gm. jar is most economical for hospital use. Thus, with Synalar Cream 0.01%, you have the superiority of a modern topical corticosteroid shown to be more effective than 1% hydrocortisone[1-3] plus the economy that makes therapy practical for use in more dermatologic conditions, in long-term maintenance, with occlusive dressings in resistant cases, and in extensive area involvement.

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** 1. *General*—Synalar Cream 0.01% is virtually nonsensitizing and nonirritating. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pre- females has not absolutely been established. Therefore, they should n used extensively on pregnant patients, in large amounts, or for prolo periods of time. 2. *Occlusive dressing method*—With occlusion of exte areas, systemic absorption of the corticosteroid may occur, and sui precautions should be taken. Occasional patients may show contact s tivity to a particular dressing material or adhesive. Miliaria, folliculiti pyodermas have been seen infrequently with the use of this technique development of infection requires appropriate antibacterial therapy an continuation of the occlusive dressing method. Local atrophy and s have been reported with protracted occlusive dressing therapy. While le relapses can be expected to occur in many psoriatic patients, remiss may persist for several weeks to several months in favorable cases patient whose psoriasis is in an active stage, with recent appearance of lesions, may not be a good candidate and may show early relapse. S plastic films may be flammable, and due care should be exercised in use. Similarly, caution should be employed when such films are used c left near children to avoid the possibility of accidental suffocation. **Effects:** Side effects are not ordinarily encountered with topically app corticosteroids. As with all drugs, however, a few patients may react vorably to Synalar under certain conditions. **References:** 1. Cahn, M. M., Levy, E. J.: J. New Drugs 1:262 (Nov.-Dec.) 1961. 2. Meenan, F. O. J. Med. Ass. 52:75 (Mar.) 1963. 3. Robinson, H. M., Jr., Raskin, J., and Duns W. J. R.: Southern Med. J. 56:797 (Jul.) 1963.

of a modern corticosteroid economy of hydrocortisone

Now...a choice of 3 economical sizes



120 Gm. jar 15 Gm. tube 45 Gm. tube

fluocinolone acetonide — an original steroid from

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Norinyl® tablets

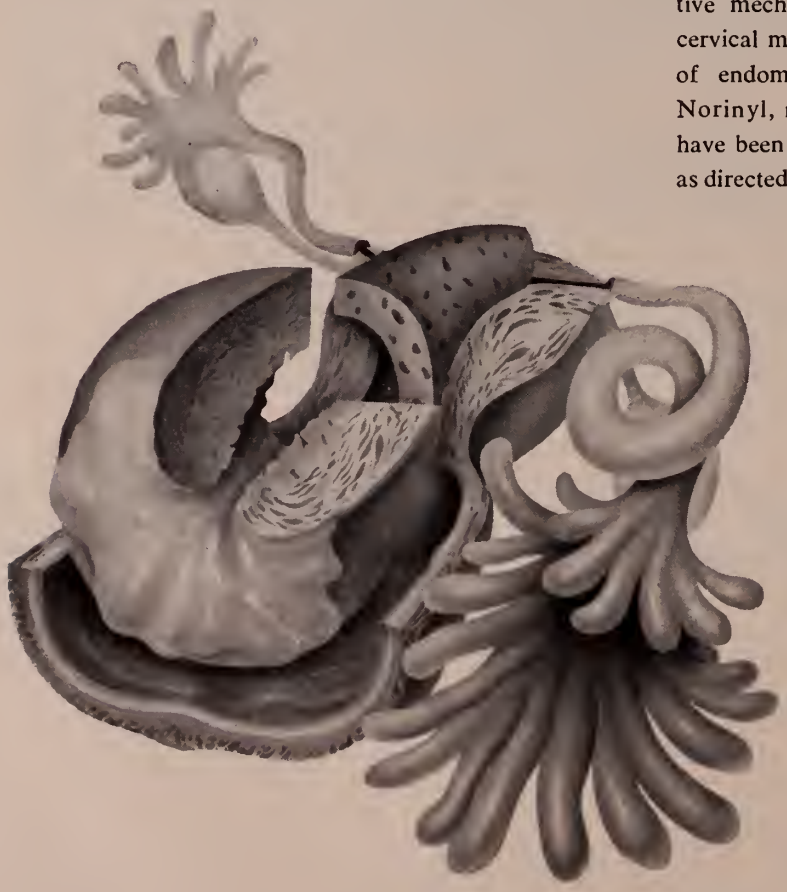
(norethindrone 2 mg ĉ mestranol 0.1 mg)

for multiple contraceptive action that has produced a record of unexcelled effectiveness

inhibition of ovulation by means of 2 time-proved hormonal agents

production of a cervical mucus hostile to sperm motility and vitality

creation of an endometrium unreceptive to egg implantation



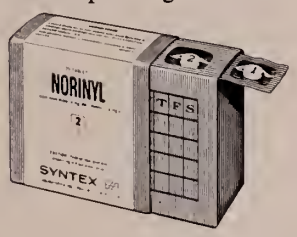
no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus[1-13] and an acceleration of endometrial changes.[1-3,7-16] With Norinyl, no unplanned pregnancies have been reported to date when used as directed.

plus important supportive benefits that help her through those critical early months of oral contraception

low incidence of side effects
Low incidence of BTB and spotting, nausea and amenorrhea tends to minimize side effect problems and increases patient cooperation.

no confusion about dosage
An unbreakable "confusionproof" package makes it easy to adhere to prescribed dosage schedule: individually sealed tablets numbered from 1 through 20 *plus* monthly calendar record enables patient to double-check dosage intake by day and corresponding tablet number.



Contraindications: Thrombophlebitis or pulmonary embolism (current or past). Existing evidence does not support a causal relationship between use of Norinyl and development of thromboembolism. While a study which was conducted does not resolve definitively the possible etiologic relationship between progestational agents and intravascular clotting, it tends to confirm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.
Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.
Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism.
Side Effects: Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.
NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.
Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)
Availability: Dispensers of 20 and 60 tablets; bottles of 100.

References: 1. Council on Drugs. JAMA 187:664 (Feb. 29) 1964. 2. Bryans, F. E.: Canad Med Ass J 92:287 (Feb. 6) 1965. 3. Goldzieher, J. W.: Med Clin N Amer 48:529 (Mar.) 1964. 4. Cohen, M. R.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965. 5. Hammond, D. O.: Ibid. 6. Rice-Wray, E., Goldzieher, J. W., and Aranda-Rosell, A.: Fertil Steril 14:402 (Jul.-Aug.) 1963. 7. Goldzieher, J. W., Moses, L. E., and Ellis, L. T.: JAMA 180:359 (May 5) 1962. 8. Kempers, R. D.: GP 29:88 (Jan.) 1964. 9. Tyler, E. T.: JAMA 187:562 (Feb. 22) 1964. 10. Rudel, H. W., Martinez-Manautou, J., and Maqueo-Topete, M.: Fertil Steril 16:158 (Mar.-Apr.) 1965. 11. Flowers, C. E., Jr.: N Carolina Med J 25:139 (Apr.) 1964. 12. Goldzieher, J. W.: Appl Ther 6:503 (June) 1964. 13. The Control of Fertility. Report adopted by the Committee on Human Reproduction of the American Medical Association. JAMA 194:462 (Oct. 25) 1965. 14. Flowers, C. E., Jr.: JAMA 188:1115 (June 29) 1964. 15. Merritt, R. I.: Appl Ther 6:427 (May) 1964. 16. Newland, D. O.: Paper presented at Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965. Reported in Med Sci 16:26 (Nov.) 1965.

norethindrone—an original steroid from
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Norinyl® tablets
(norethindrone 2 mg. ē mestranol 0.1 mg.)

for multiple contraceptive action

MOLECULAR REMODELING—

laboratory exercise or clinical necessity?

More than twenty-five years have passed since the discovery of the diuretic activity of sulfanilamide started pharmacologists on a succession of molecular remodelings to find the ideal diuretic.

Diuresis—a sought-after clinical effect from an unwanted side effect

It started in 1937 when a clinician reported that the administration of a sulfonamide was sometimes accompanied by an unexplainable side effect—metabolic acidosis.[1] Three years later the side effect was explained. The sulfonamide radical of sulfanilamide inhibited carbonic anhydrase,[2] the enzyme responsible for converting carbon dioxide and water to hydrogen ions and bicarbonate ions.

Later, other investigators showed by dog experiments that metabolic acidosis probably resulted when the inhibition of carbonic anhydrase upset the exchange of hydrogen and sodium ions, causing increased excretion of sodium as the bicarbonate.[3]

It was twelve long years after the first report of the unexplainable side effect (metabolic acidosis) that it was finally shown that large doses of sulfanilamide administered to edematous patients were indeed capable of promoting diuresis.[4] However, the possibility of toxic effects from its prolonged use and its relatively weak diuretic action made it impractical for clinical use as a diuretic.[5]

Because the inhibition of carbonic anhydrase seemed to be the key to effective diuresis, investigators began to look for more potent enzyme inhibitors —in the hopes that they would be more effective diuretics.

The most important of these early compounds, acetazolamide, enjoyed several years of fairly wide clinical use.

Its carbonic anhydrase inhibitory activity was several hundred times greater than that of sulfanilamide.[6] The increase in inhibitory activity, however, increased not only the excretion of sodium and bicarbonate ions, but also the excretion of potassium.[7] And, like its predecessor, acetazolamide precipitated mild acidosis. Its prolonged use could result in hypokalemic acidosis.[7]

The 'thiazides'—an answer to the metabolic acidosis caused by carbonic anhydrase inhibition

Despite the fact that the sulfonamide group appeared to be responsible for carbonic anhydrase inhibition which in turn appeared to be responsible for diuresis, investigators began to synthesize compounds with structural alterations to the sulfonamide group.

The first major breakthrough came with the synthesis of chlorothiazide. Altering the sulfonamide group did indeed alter the ability of chlorothiazide to inhibit carbonic anhydrase—it was only 1/10th as potent as acetazolamide in inhibiting the enzyme.[8] Despite the drop in inhibitory potency, however, chlorothiazide proved to be an effective diuretic—an observation that led to the conclusion that its diuretic action was due to some mechanism other than its action on carbonic anhydrase.[9, 10]

For effective diuresis, chlorothiazide was administered in daily dosages ranging from 250 to 2000 mg.[11] It increased the excretion of sodium and chloride; and, to a lesser extent, potassium and bicarbonate.[11] The excretion of potassium appeared to be maximal at higher dose levels at which, theoretically, the carbonic anhydrase inhibitory effect is more active.[11] Its prolonged use, therefore, could sometimes result in metabolic hypokalemic, hypochloremic alkalosis.[7]

Naturetin—effective diuresis with more favorable electrolyte balance

Other thiazides followed—with improvements being aimed at two particular areas: 1. attempts to increase diuretic action in relation to the milligram potency of the drug, and 2. attempts at a more favorable sodium/potassium ratio in the urine, i.e., to decrease the excretion of potassium while maintaining the excretion of sodium.[12]

One of these, Naturetin, Squibb Bendroflumethiazide, has made advances on both these points. "By adding a 3-benzyl radical to hydroflumethiazide a rather dramatic reduction in dose range is accomplished. With this drug, effective sodium excretion is obtained with doses between 2.5 and 10 mg., which is a 200 to 1 ratio as compared to chlorothiazide..."[13]

Moreover, due probably to its virtual lack of carbonic anhydrase inhibition, Naturetin (bendroflumethiazide) has been shown to cause less potassium and bicarbonate loss and less alteration in urinary pH than either chlorothiazide or hydrochlorothiazide.

Naturetin is outstandingly effective not only in establishing, but also in maintaining, excretion of retained fluid in edematous patients. And its duration of action is sufficiently prolonged to allow a single daily administration in most patients. Naturetin is also an effective antihypertensive agent.

Contraindications: Severe renal impairment; previous hypersensitivity.

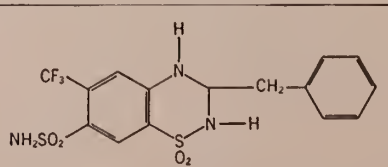
Warning: Ulcerative small bowel lesions have occurred with potassium-containing thiazide preparations or with enteric-coated potassium salts supplementally. Stop medication if abdominal pain, distension, nausea, vomiting, or G.I. bleeding occur.

Precautions: The dosage of ganglionic blocking agents, veratrum, or hydralazine when used concomitantly must be reduced by at least 50% to avoid orthostatic hypotension. Electrolyte disturbances are possible in cirrhotic or digitalized patients.

Side Effects: Bendroflumethiazide may cause increases in serum uric acid, unmask diabetes, increase glycemia and glycosuria in diabetic patients and may cause hypochloremic alkalosis, hypokalemia; cramps, pruritus, paresthesias, and rashes may occur.

Supplied: Naturetin (Squibb Bendroflumethiazide) 5 mg. and 2.5 mg. tablets. Also available Naturetin c K [Squibb Bendroflumethiazide (5 or 2.5 mg.) with Potassium Chloride (500 mg.)]. For full information, see Product Brief.

References: **1.** Southworth, H.: Proc. Soc. Exper. Biol. & Med. *36*:58, 1937. **2.** Mann, T. and Keilin, D.: Nature *146*:164, 1940. **3.** Pitts, R. F., and Alexander, R. S.: Am. J. Physiol. *144*:239, 1945. **4.** Schwartz, W. B.: New England J. Med. *240*:173, 1949. **5.** Friedberg, C. K., in Moyer, J. H., and Fuchs, M.: Edema Mechanisms and Management, Philadelphia, W. B. Saunders Co., 1960, p. 259. **6.** Cumming, J. R.; Tabachnick, E., and Seelig, M., in Moyer, J. H., and Fuchs, M.: op. cit., p. 254. **7.** Werko, L., in Moyer, J. H., and Fuchs, M.: op. cit., p. 188. **8.** Beyer, K. H., Jr., in Moyer, J. H., and Fuchs, M.: op. cit., p. 274. **9.** Maren, T. H., and Wiley, C. E.: J. Pharmacol. & Exper. Therap. *143*:230, 1964. **10.** Earley, L. E., and Orloff, J.: Ann. Rev. Med. *15*:149, 1964. **11.** Fuchs, M., and Mallin, S. R., in Moyer, J. H., and Fuchs, M.: op. cit., p. 276. **12.** Ford, R. V., in Moyer, J. H., and Fuchs, M.: op. cit., p. 290. **13.** cited in Fuchs, M., and Mallin, S. R. (ref. 11): op. cit., p. 283.



Naturetin®
SQUIBB BENDROFLUMETHIAZIDE
to reduce excess fluid
or high blood pressure



Now, now, Mrs. Forsythe, we've never lost a cold patient yet.

When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

She will breathe easier when you prescribe Novahistine LP. Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. A dose of two tablets taken in the morning and repeated in the evening will usually keep air passages clear for 24 hours.

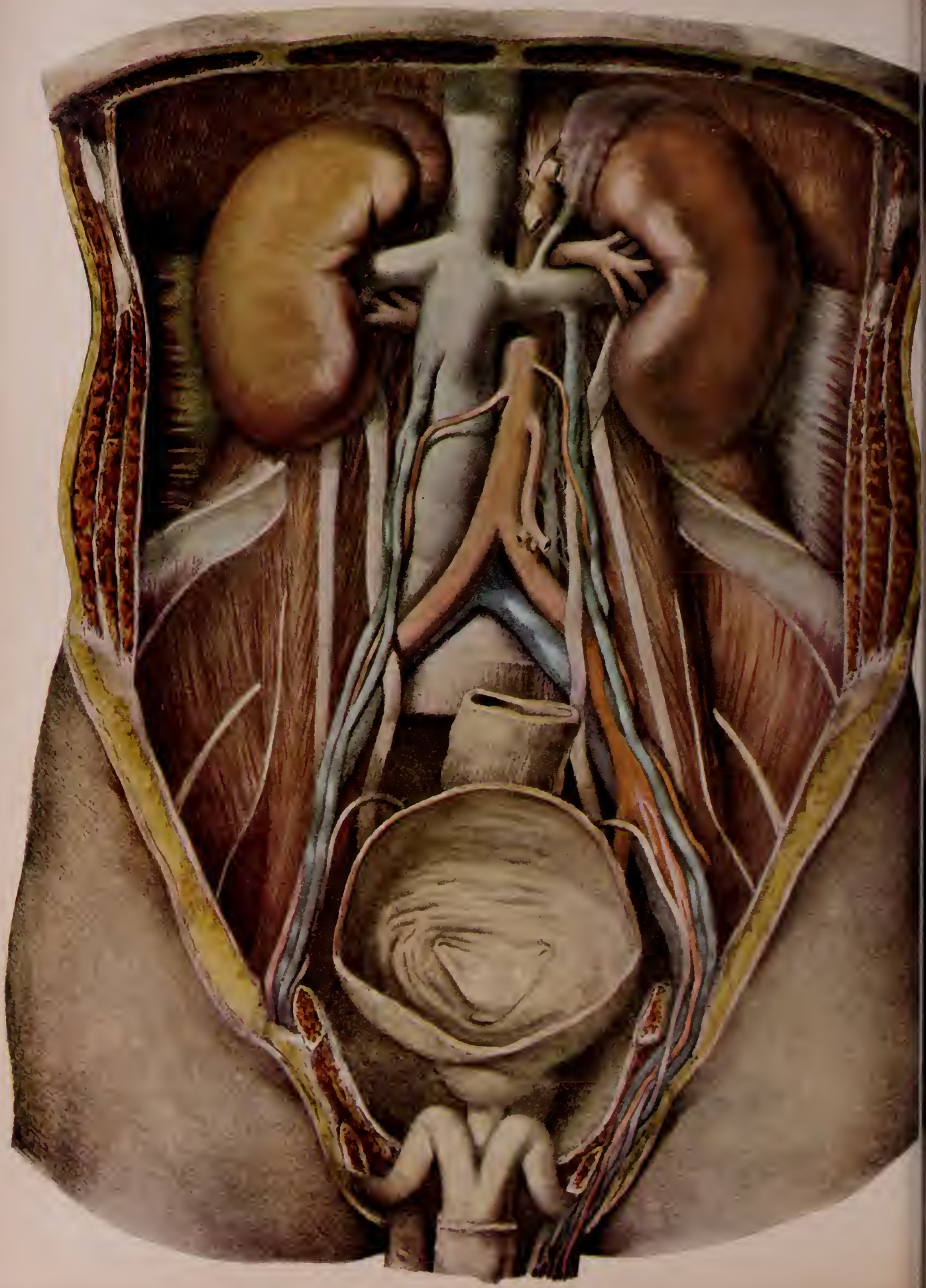
Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis DOW

NOVAHISTINE® LP

For relief of nasal congestion.



Wide-range bactericidal action for genitourinary infections

NEW OMNIPEN® (AMPICILLIN) WYETH

A penicillin that exhibits effectiveness within the gram-positive spectrum of penicillin G* and the gram-negative spectrum of chloramphenicol and the tetracyclines.*

Active at foci of infections—kidney, ureter, bladder or urethra.

Effective against many gram-negative and gram-positive pathogens—thus may be valuable not only in genitourinary but also in common respiratory and gastrointestinal infections.

Normally produces high and persistent levels in blood and high concentrations in bile and urine.

Significant inherent stability.

**Exclusive of penicillinase-producing bacteria.*

Indications: Urinary tract infections, especially those caused by *E. coli*, *Proteus mirabilis*, and *Streptococcus faecalis* and *viridans;* respiratory infections caused by *H. influenzae*, pneumococci, streptococci, and nonpenicillinase-producing staphylococci; and gastrointestinal infections caused by *Shigella* and *Salmonella*, including *Sal. typhosa.*



Contraindications: Hypersensitivity to penicillin; infections due to penicillinase-producing staphylococci and other penicillinase-producing bacteria.

Precautions: If allergic reaction occurs, discontinue ampicillin and administer epinephrine, corticosteroids, antihistamines and/or pressor amines as indicated. Transient moderate elevation of SGOT values of undetermined significance was noted in a few infants. Liver and kidney function as well as hematopoietic tests are advisable during therapy, particularly in infants. As with other antibiotics, precautions should be taken against gastrointestinal superinfection. Safety for use in pregnancy has not been established.

Adverse Reactions: Occasional mild side effects as urticaria, skin rash, pruritus, diarrhea, nausea and vomiting. There have been no reports of blood dyscrasias, liver or kidney damage. Anaphylaxis has been reported.

Composition: Capsules, 250 mg.

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ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

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Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

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Pleasant-tasting Alertonic is pipradrol hydrochloride—an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that can often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

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Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

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against the usual gram-negative urinary pathogens

Why use five...where **one** will do?



In a recent 217-patient hospital study,[1] urinary tract infections were treated with a variety of widely prescribed antimicrobial agents including: a sulfonamide (40 patients), chloramphenicol (20 patients), nitrofurantoin (33 patients), nalidixic acid (30 patients), tetracycline (27 patients), colistimethate sodium (22 patients)...and 2 combinations of 5 agents each (45 patients). The 2 combinations were selected to afford maximal theoretical antibacterial coverage against the usual urinary pathogens. They were (1) tetracycline, chloramphenicol, nitrofurantoin, ristocetin and polymyxin B; and (2) tetracycline, chloramphenicol, erythromycin, nitrofurantoin and colistimethate sodium.

This clinical study shows that the two combinations of antibiotics were not superior to some of their single components. The authors point out that antibiotic antagonism often negates theoretical advantages of multiple therapy. Coly-Mycin Injectable (colistimethate sodium) was one of the single components that was shown to be equal to the combinations and eradicated bacteriuria in two-thirds of the patients.

Theoretical choice of multiple antibacterial therapy has been shown to be no more effective than one well-chosen agent which also offers least patient exposure to possible side reactions, toxicities, allergic manifestations and higher drug costs.

1. McCabe, W. R., and Jackson, G. G.: New England J. Med. 272:1037, 1965.

in gram-negative urinary tract infections often the single well-chosen agent



Coly-Mycin® Injectable
(colistimethate sodium)

Indications: Especially indicated for the treatment of severe acute and resistant chronic urinary tract infections due to sensitive strains of gram-negative organisms. Also indicated in respiratory tract, surgical, wound and burn infections and in septicemia due to sensitive organisms. Particularly indicated when any of these infections are caused by sensitive strains of *Pseudomonas aeruginosa.*

Adverse Reactions: Occasional reactions such as circumoral paresthesias, tingling of the extremities, pruritus, vertigo or dizziness may occur. Reduction of dosage may alleviate symptoms. Therapy need not be discontinued, but such patients should be observed with extra care.

Warning: Patients should be cautioned not to drive vehicles or use hazardous machinery while on therapy.

Precautions: In cases of impaired or suspected renal impairment, use with greater caution and reduce dosage in proportion to extent of impairment. Transient elevations of BUN have been reported. As a routine precaution, appropriate blood studies should, therefore, be made during prolonged therapy.

As with all polypeptides, the possibility of muscular weakness, including apnea, due to inadvertent overdosage or normal dosage in the presence of impaired renal function, should not be overlooked. In cases of apnea, medication should be promptly discontinued and assisted respiration given until serum levels fall and normal breathing is restored.

Other antibiotics, such as kanamycin, streptomycin, dihydrostreptomycin, polymyxin, and neomycin, may also have varying neurotoxic or nephrotoxic potential. They should be used with great caution concomitantly with Coly-Mycin Injectable (colistimethate sodium).

For deep intramuscular injection only.

Dosage: By the I.M. route only, in 2 to 4 divided doses ranging from 1.5 to 5 mg./Kg./day (0.7 mg. to 2.3 mg./lb./day). Average adult dose is 2.5 mg./Kg./day (1.1 mg./lb./day). In the presence of bacteremia, septicemia, or other serious infection, greater than average doses may be required; however, maximum daily doses should not exceed 5 mg./Kg. (2.3 mg./lb.) where renal function is normal.

Not recommended against Proteus.

Colistin is also available (as colistin sulfate) in: Coly-Mycin® Pediatric for Oral Suspension (not for systemic use), and Coly-Mycin® Otic with Neomycin and Hydrocortisone.

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EDITORIALS

The Physician and the Icarus Syndrome

Physician-aviators are four times as likely to be killed as are pilots of other light aircraft. This is the conclusion of a study by the Federal Aviation Agency* with a team headed by Stanley R. Mohler, M.D., chief of the Aeromedical Applications Division. In a 2-year period, one general aviation pilot per 800 was killed in a flight accident. Among physician-pilots, the ratio was one per 200 doctors.

The research further revealed that "risk-taking attitudes and judgments appear to be the key underlying thread uniting the major variables." This solemn phrasing is a way of stating that the M.D.-pilots who thus killed themselves did things like these: flew mountainous terrain at night in an unlighted area during a thunder storm for the purpose of transporting a friend to a fishing trip; overloaded aircraft (in one case, a glider rated as suitable for no more than 191 pounds was fatally piloted by a physician weighing 240 pounds); one doctor set off without asking about the weather ahead and crashed during a severe storm which had been clearly forecast in advance.

One physician insisted on taking off from an airport where the runway lights were inoperative: he was sure he could get enough illumination from the headlights of a friend's automobile. One doctor was found to have excessive blood alcohol in his blood. The blood chemistry had to be done post—mortem as the doctor flew off in a fog, both literal and figurative. In another case, the physician-pilot had overloaded himself with meprobamate — the post-mortem urine analysis showed 2.6 milligrams (per cent) in the urine and 0.95 milligrams (per cent) meprobamate in the blood. One doctor, with a history of vertigo on previous flights, approached an airport at an inverted steep angle. This physician incinerated his wife, his two children, and himself on what was listed as a "pleasure flight." In the two-year period, some 30 physicians were killed this way — and ten entire families were wiped out. Nearly all the flights were listed as recreational or pleasure trips. (In none of the thirty accidents here reported was the flight part of a medical or surgical mercy mission.)

The study gives the dry figures. The only effort at interpretation is a conclusion that it "highlights the premium physicians place on their relatively restricted opportunities for recreation."

One wonders, however, if a less simplified explanation is not needed. It reminds one of the Greek legend about Daedalus and Icarus. Daedalus was the artificer, whose technical ingenuity gave wings to man to allow him to escape from the labrynth. Icarus, however, flew too high, his wings melted and he went down. Thus the Greeks expressed (with startling historical accuracy 4000 years in advance) that he who soars too high may soon crash down.

If the psychiatrists have not as yet thought up an Icarus Syndrome, here is a chance to do so. But left unanswered is the question: why are physicians more prone to the Icarus Syndrome than bankers, lawyers, or clergymen? Perhaps the doctor's daily work keeps him so closely tied to earthly considerations that he yearns to soar when he gets the chance. Or, could the FAA be right at simply calling it a desire to take advantage of restricted recreational opportunities? Or, does the doctor get the feeling of being in control during his practice, so that he extends it elsewhere and feels that "doctor's orders" can determine everything — even the flight of a plane?

Anyone looking for a worthy research project might do worse than make an in-depth study of the Icarus Syndrome among physicians.

* Report AM 66-25, Federal Aviation Agency (Washington, D.C. 20025) entitled *Physician Flight Accidents*, issued September 1966

Confidential Communication

Under newly signed New Jersey legislation (Senate 325 of 1966), communications between psychologists and their clients or patients are "privileged." The new statute specifically states that these communications are on the same basis as attorney-client contacts. Physicians, however, have no such privilege. If, for instance, a patient thought he was a homosexual and wanted to talk to a professional person about it, he would be "safer" with a psychologist than with his family physician, a psychiatrist, or a urologist. The M.D. could be compelled to reveal in court what the patient told him in confidence. A psychologist could remain silent, since New Jersey statutes now lock such communications behind the seal of privilege. The legislature was almost unanimous in passing the bill which conferred this boon on contacts with psychologists. The legislature has never been willing to protect physician-patient communications the same way.

In a sense, communication privilege is a barrier to the discovery of truth. The purpose of a trial or a court hearing is to discover the facts. The loud silence of a key witness is a hurdle in the way of the quest for truth. However, New Jersey allows newspaper reporters to refuse to disclose their sources of information. Attorney-client, priest-penitent, and husband-wife communications are, of course, privileged. As yet, accountants have not asked for "privilege," but a case could probably be made out for giving an accountant the right to refuse to testify against his own client. With the pressure to throw the cloak around more and more communications, one can see why jurists are reluctant to set up any more stop streets on the road to truth.

But it is hard to see why psychologist's may, with legislative sanction, refuse to reveal the truths that they have discovered in their professional contacts, while the same right is not accorded to doctors of medicine.

Daniel F. Featherston, M.D. 1896-1966

We can ill afford the loss of men like Daniel Featherston. It is as if he had been born to leadership. A long-time member of the State Board of Medical Examiners, he was a vital force in carrying out the essential mission of that Board. He was Treasurer of The Medical Society of New Jersey — a chore which he carried with grace and skill. For years he headed up our Medical Defense and Insurance Committee, and became an acknowledged expert in that field. When the Society initiated a Conference Committee on Interprofessional Relations with the Judiciary and Bar, he was with it from the start. For almost two decades he was a federal and state legislative keyman.

He was a vigorous defender of any cause he thought just. The Asbury Park *Press* in a 1962 editorial called him a "crusader guarding the sanctity of the profession." He was afraid of no one, and entangled with many of the greats of medicine when he thought they were wrong. While he was a fierce defender of our profession, he denounced (in his words) "unavailability, arrogance, and high fees" in doctors whenever he found these traits.

He plunged himself into work for his hospitals, his church, the American College of Surgeons, the American Cancer Society, and the AMA. In 1942, at the age of 46, scorning the easier life back home, he applied for — and received — a commission in the Medical Corps of the Army and served as a lieutenant colonel during the war.

He maintained a busy surgical practice, but he was never too busy to help us all. He took seriously the injunction to participate actively in whatever was important, and he scorned a safe seat on the sidelines. It is hard to realize that this bundle of energy is now stilled. We are grateful that he was with us so long. (See obituaries, page 568 of this JOURNAL)

ORIGINAL ARTICLES

To handle renal insufficiency you must know how kidney function is alerted by disease. Here's how.

The Diagnosis and Treatment of Renal Insufficiency*

Norman Lasker, M.D./Hillside

The diagnosis and treatment of renal failure requires some understanding of normal renal function and how this may be altered by renal disease. One concept of the function of the proximal tubule cell is shown in Figure 1. The relative intracellular negativity is produced by the passive diffusion of potassium out of the cell. The potential difference is less across the luminal membrane than across the peritubular membrane because of the former's greater permeability to sodium. The active "sodium pump" is at the peritubular surface and actively extrudes sodium in exchange for potassium. The movement of sodium into the cell from the urine is due to the concentration differences produced by the active extrusion of sodium and the intracellular negativity. Under normal conditions all of the filtered potassium is thought to be reabsorbed in the proximal tubule and that which appears in the urine is secreted in exchange for sodium in the distal nephron. Chloride moves passively from the tubular lumen to the peritubular fluid because of the relative negativity of the tubular lumen.

If the sodium pump is damaged or the proximal urine sodium concentration is decreased, sodium reabsorption in the proximal tubule should decrease. In many patients with chronic renal disease there is an inability to conserve sodium. This could be due to tubular damage, hormonal alterations, changes in intrarenal blood flow, or a solute diuresis in the functioning nephrons.[1] There is evidence that the few functioning nephrons in azotemic patients with chronic renal disease have a normal or supernormal filtration rate resulting in a large urea load per nephron. Since over 99 per cent of the filtered sodium is normally reabsorbed by the tubules, a de-

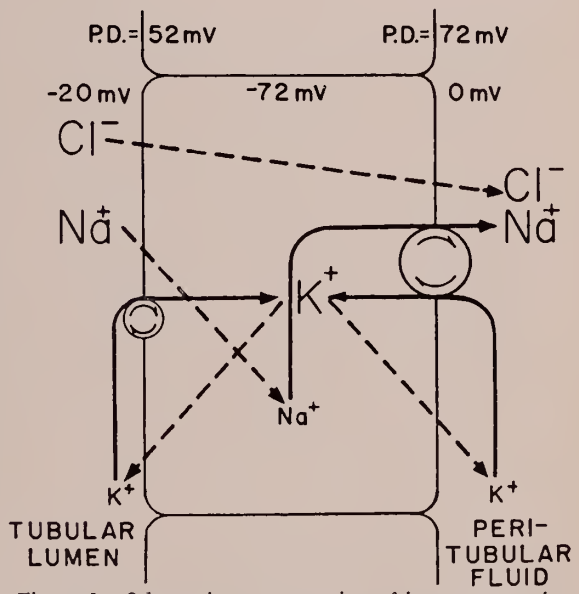


Figure 1. Schematic representation of ion transport in a proximal tubular cell. *Dashed lines*, passive diffusion down electrochemical gradients; *solid* lines, active transport. (From Pitts, R. F.: Prog. Cardiovas. Dis. 3:537, 1961)

* Read May 16, 1966, at Atlantic City, before the session of cardiovascular diseases, chest diseases, and general practice of The Medical Society of New Jersey. This work is from New Jersey College of Medicine and Dentistry, where Dr. Lasker is Associate Professor of Medicine.

crease in sodium reabsorption to approximately 85 per cent in the relatively few remaining nephrons can produce a significant sodium diuresis despite a greatly decreased total glomerular filtration rate. It is not uncommon for patients with severe renal insufficiency to excrete over two liters of urine containing more than 60 milli-equivalents of sodium per day regardless of the salt intake. Thus, placing such patients on strict salt restriction can result in hypovolemia, a further decrease in renal blood flow and glomerular filtration rate, and an accentuation of the uremic state.

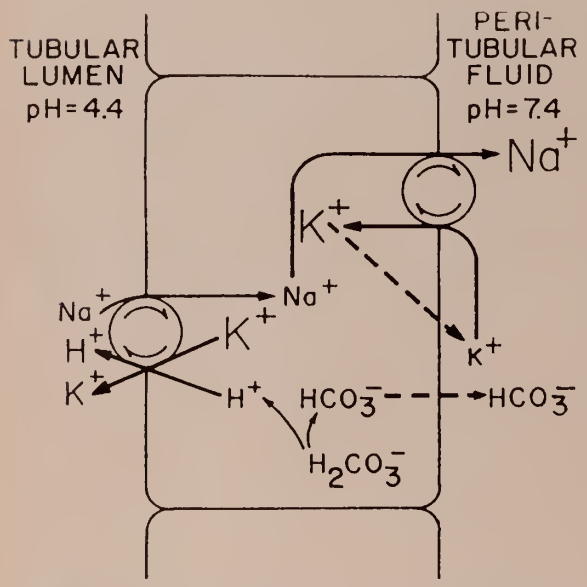


Figure 2. Schematic representation of ion transport in a collecting-duct cell. (From Pitts, R. F.: Prog. Cardiovas. Dis. 3:537, 1961)

Figure 2 shows the pattern of sodium reabsorption in the distal nephron. Besides the peritubular sodium-potassium "exchange pump," there is thought to be an active reabsorptive mechanism in the luminal membrane which reabsorbs sodium in exchange for potassium or hydrogen ions. This mechanism is under the influence of aldosterone but is primarily controlled by the amount of sodium presented to the exchange site. Most (or perhaps, all) of the potassium which appears in the urine is secreted by exchanging for sodium. Hence, patients with chronic renal disease and a relatively large urinary sodium excretion will continue to lose potassium in the urine, maintaining a normal serum potassium despite a decreased glomerular filtration rate.

Although chloride is neither an acid nor a base at the pH of body fluids, it can play an important role in the correction of hypochloremic hypokalemic alkalosis. Attempting to correct the alkalosis by providing potassium salts without chloride results in the building up of the negative charge in the proximal tubular lumen. Bicarbonate is not as diffusable as chloride and cannot follow the sodium to decrease the negative charge left behind by sodium reabsorption.[2] This build up of negativity inhibits sodium reabsorption. The delivery of increased amounts of sodium to the distal nephron causes an increase in potassium and hydrogen ion secretion which decreases the effectiveness of the potassium therapy.

Berliner and Davidson[3] have shown that the reduction of renal blood flow to approximately 40 per cent of normal in water-loaded dogs may result in increased renal sodium and water reabsorption and a hypertonic urine despite the absence of ADH.[11] The decreased GFR and enhanced sodium reabsorption results in a decreased urine volume in the collecting tubule. It is postulated that despite the absence of ADH,[11] small amounts of water can pass into the hypertonic medulla resulting in a small volume of hypertonic urine with a low sodium concentration. On the other hand, in the presence of tubular and/or medullary damage, sodium and water reabsorption is inhibited, and the urine would be expected to be dilute with an increased sodium concentration. These principles may be applied to the differential diagnosis of acute renal failure as shown in Table I. The determination of urine osmolality is to be preferred over specific gravity measurements since it is less influenced by large molecules such as proteins, glucose, and bilirubin which may be present in the urine of patients with acute renal failure. (A urine osmolality of 500 $mO_sm/kgm\ H_2O$ represents a specific gravity of approximately 1.015.)

TABLE I
D.D.—ACUTE RENAL FAILURE

	Urine Concentration $mO_sm/kgmH_2O$	Urine Na+ Concentration mEq/L	Total Anuria May Occur	Urine Sediment
Pre-Renal	>500	<30	−	Few hyaline and rare granular casts
Glomerulitis	>500	<30	+	Hemoglobin and RBC casts. Tubular cells, RBC's and WBC's
Acute Cortical Necrosis	Variable	Variable	+	RBC's—Hemoglobin casts
Acute Medullary Necrosis	<500	>30	+	WBC's and clumps, tubular cells and cellular casts, RBC's and rarely papillae
Acute Tubular Necrosis	<500	>30	−	Many tubular cells, cellular casts and coarsely granular casts. RBC's, RBC casts uncommon. H_b casts partic. if hemolysis
Post-Renal Early	>500	<30	+	Scarce sediment, WBC's and RBC's, finely granular and hyaline casts
Late	<500	>30		

In pre-renal failure due to shock, blood loss, or cardiac insufficiency, the urine concentration is usually above 500 $mO_sm/kgm\ H_2O$ and the sodium concentration less than 30 mEq/L. Total anuria (no urine output for 24 hours) is not seen and the urine sediment is scarce. The early diagnosis of pre-renal failure is vital since its prompt correction can prevent histological damage and the development of acute tubular necrosis.

Acute glomerulitis as seen in acute glomerulonephritis, sub-acute bacterial endocarditis, allergic vasculitis, and lupus nephritis is characterized in its early stages by relatively good tubular function despite a decreased glomerular filtration rate. This results in a concentrated urine containing small amounts of sodium. The sediment is characteristic. Acute cortical necrosis is a rare condition seen in obstetrical patients associated with premature placental separation and uterine hemorrhage. It can occur in infants following a gastroenteritis with dehydration and in a variety of clinical settings in both adults and children. Like acute glomerulitis it may result in total anuria.

Acute medullary necrosis is an overwhelming pyelonephritis due to bacterial invasion in an ischemic scarred medulla. It occurs in diabetics, patients with long standing pyelonephritis, urinary tract obstruction, and possibly analgesic abuse. The medullary damage results in a dilute urine with increased sodium concentration and the sediment of infection. Acute tubular necrosis results from inadequate correction of the causes of pre-renal failure as well as nephrotoxic drugs such as carbon tetrachloride, ethylene glycol, heavy metals, and incompatible transfusions, RBC hemolysis, burns, crush injuries, and electrolyte disturbances. In early obstructive uropathy, the tubular back pressure may decrease GFR[9] and allow for enhanced sodium and water reabsorption. After tubular or interstitial damage occurs, the urine may become dilute with increased amounts of sodium. The diagnosis here is best made by history, x-ray, and urologic evaluation.

It is important to recognize that the variations in urine osmolality and sodium concentration shown in Table I depend on the patient's previous state of hydration and salt ingestion. With the exception of medullary necrosis it is assumed that the kidneys were normal before the onset of acute renal failure.

If one measured RPF[10] in patients with acute tubular necrosis by methods not depending on good urine volume, such as radioactive krypton or indocyanine green, it is 30 to 60 per cent of normal.[4] Since many patients with chronic renal failure produce large amounts of urine with this degree of reduction in RPF, the reason for the oliguria in acute tubular necrosis is not obvious. Trueta[5] sug-

gested that blood is shunted to the medulla in acute tubular necrosis, leading to an ischemic cortex and dilating the medullary vessels which then compress the medullary nephrons and stop urine flow. Another theory is that the tubular urine leaks out into the interstitium through tubules damaged by ischemia or nephrotoxins and is returned to the circulation by lymphatic channels.

The oliguria has also been explained by casts blocking the tubules. Recent work in mercury-induced acute renal failure[6] suggests that a decrease in GFR[9] is primary and not due to tubular factors. It may be due to relative dilatation of the efferent arterioles to explain the maintenance of RPF[10] without GFR.[9] Whatever the etiology of acute tubular necrosis, there may be a stage before irreversible tissue damage occurs when increasing renal blood flow or tubular flow is indicated. Mannitol has been used for this purpose. One vial of mannitol (12.5 Grams) is given directly intravenously. A urine output of 40 cubic centimeters per hour in the next three hours indicates a good therapeutic response and a 10 per cent mannitol drip is set up to maintain the output at 100 cubic centimeters per hour. If the hourly urine output after one vial increases to less than 40 cubic centimeters, a second test dose is given. If there is no significant response to two vials, no more is given because of the danger of precipitating pulmonary edema in the oliguric patients.

In the patient with established renal failure due to renal damage, conservative and dialytic treatment is continued as long as there is a chance of recovery. This may occur up to six weeks following the onset of oliguria and up to ten days following the onset of total anuria not due to urinary tract obstruction. The decision to maintain life by dialysis for these periods may be aided by the judicious use of the renal biopsy.

The treatment of acute and chronic renal failure has certain striking differences. Although the urine may contain more than 80 mEq/L of sodium in acute tubular necrosis, the small urine volume makes sodium and water restriction mandatory. In chronic renal failure, however, the urine output is frequently over 1500 ml/day and the salt loss over 60 mEq/day which must be replaced. The fluid intake in acute renal failure is restricted to 0.2 ml/kgm/hr plus the previous day's urine output. This small amount of fluid takes into account the endogenous water produced by breakdown of fat, carbohydrate, and protein. In chronic renal failure, the fluid intake is adjusted to match the urine output and prevent thirst. Daily weights are essential — in acute renal failure the patient should lose 8 to 16 ounces a day, while in chronic renal failure the weight should be stable. Hyponatremia means overhydration in acute renal failure whereas in non-edematous patients with chronic renal failure it frequently indicates a salt deficit and hypovolemia.

The usual caloric regimen of the patient with acute renal failure is limited to 400 to 800 calories of carbohydrate given for maximum sparing of protein. This is given with a minimum of water, salt, and potassium because of the patient's inability to excrete these substances. In chronic renal failure the patient needs a higher caloric intake than is usually possible because of anorexia and vomiting. Recently a diet has been introduced in the treatment of chronic renal failure based on the finding by Giordano[7] that uremic patients on a low protein diet will divert their urea nitrogen production to form non-essential amino acids if the essential amino acids are provided. The diet consists of 18 Grams of protein, 30 calories per kilogram, and 53 mEq of sodium. It contains no meat, fish, or cheese and must be supplemented with 500 milligrams of methionine, multivitamins, and iron. In patients with creatinine clearances below 3.5 ml/min and urine outputs of less than 1000 ml/day, there is a tendency for overhydration on this diet. In patients with creatinine clearances above 10 ml/min, the diet is not needed. If active infection is present, the patients do not become anabolic. The diet can be supplemented with Sauna baths to help control overhydration (see appendix).

Several patients have been able to stop chronic

dialysis while on the diet and return to work. Gastro-intestinal symptoms clear swiftly, and the blood urea nitogen, uric acid, and phosphate levels decrease remarkably although the progression of the renal disease is not halted. The diet may produce acidosis and hyperkalemia which can be controlled with bicarbonate of soda.

Hyperkalemia is a catastrophic problem in acute renal failure. Its treatment requires the removal of sources of potassium including dietary, necrotic tissue, infection, and hematomas. Calcium and sodium salts will antagonize potassium while alkalinization and glucose and insulin will drive the potassium into the cells and temporarily decrease the toxic high extra-cellular intracellular ratio. The removal of potassium from the body is usually accomplished by resins or dialysis. Kayexalate® resin and sorbitol provide an effective combination. Kayexalate removes one milli-equivalent of potassium from the body and contributes one milli-equivalent of sodium. Since it causes impaction in the intestines, it is best given with sorbitol which suspends it and also causes diarrhea. The combination may be given orally or rectally (See Table II).

TABLE II

Use of Kayexalate® and Sorbitol in Hyperkalemia

Kayexalate®—Sodium cycle exchange resin—one gram removes one mEq of K+ and adds one mEq of Na+.

Sorbitol—Poorly absorbed polyhydric alcohol which prevents resin impaction.

Enema: 150 mls of 20% Kayexalate® in 25% sorbitol given t.i.d. as retention enema.

Oral: 50 mls of 30% Kayexalate® in H_2O flavored with sherry q.i.d. Give with sorbitol in dose determined by oral administration of 15 mls of 70% sorbitol q2h until diarrhea develops. This total is given once daily.

Peritoneal dialysis is an effective but slow way of removing potassium. In severe hyperkalemia it should be combined at the onset with one of the emergency technics, such as intravenous glucose and insulin utilizing one unit of insulin for 3 Grams of glucose. For acute and chronic peritoneal dialysis we prefer the Trocath stylus† which fits inside the dialysis catheter and makes a smaller hole in the abdominal wall and peritoneum.

We have maintained patients on chronic peritoneal dialysis for up to three years with a permanent Barry prosthesis.[8] The prime problem with a prosthesis is peritonitis. This is particularly evident in patients on home peritoneal dialysis. However, the multipuncture Trocath technic can control this problem. We now have two patients on home peritoneal dialysis for eleven and ten months. Dr. Thompson of Morristown and Dr. Gionti of Denville are doing the home dialysis on these patients. The most practical way to handle the large load of patients requiring chronic dialysis is by the home technic. Peritoneal dialysis is not as efficient as hemodialysis. Because of emotional and physical factors, small women do better than large men with this modality. Home hemodialysis is difficult but feasible providing an intelligent, well-motivated spouse or nurse is available.

Finally, renal homotransplantation is very exciting but still experimental. Chronic dialysis does not produce a "normal" patient since he may develop metastatic calcifications or peripheral neuropathy; and he remains anemic. A successful transplant does produce a "normal" patient but bone marrow suppression produced by the necessary immunosuppressive drugs results in infection and bleeding. These patients usually die within two years. Renal transplantation is a promising method, but at the present time offers less chance of long-term survival than chronic dialysis in end-stage kidney disease.

Appendix

LOW PROTEIN DIET FOR CHRONIC RENAL FAILURE

Adapted from Shaw, A.B., Bazzard, F. J., Booth, E. M., Nilwarangkur, S., and Berlyne, G. M.: Quarterly Journal of Medicine, 34:237 (April, 1965)

†Available as Trocath from Don Baxter, Inc., Glendale, Calif.

Breakfast
Fruit, juice, grapefruit and sugar
Bacon rinds and fat (crisply grilled — NO LEAN) on wheat starch bread.
or Tomato or fried apple rings.
Wheat starch bread, toast.
Butter (from day's allowance).
Marmalade, Honey, or Jam.

Mid-Morning
Fruit juice or tea (with milk from allowance).
Special biscuits (wheat starch).

Lunch
VEGETABLES (not peas, beans, or lentils) as a pie with wheat starch and vegetable margarine pastry,
or as a pie with 5 oz. potato topping,
or as a curry + 3 oz. (cooked weight) boiled rice,
or 3 oz. boiled rice + savory fried vegetables.
PUDDINGS Fruit crumble + wheat starch + vegetable margarine + sugar, topping,
or Fruit pie + wheat starch and vegetable margarine pastry,
or Fruit or fruit mold (wheat starch or cornflour thickening) (+ 1 oz. cream 1-2 weekly, only),
or Fruit fool (fruit puree + wheat starch or cornflour sauce),
or Boiled rice + ½ egg yolk, spread with jam, and meringue topping (½ egg white),
or Fruit + ½ egg yolk, with meringue topping (½ egg white),
or Sponge pudding (wheat starch + ½ egg) + syrup.

Mid-Afternoon
Fruit juice + sugar or tea (with milk from allowance).
Wheat starch bread + butter + jam or honey,
or Special biscuits or cake (wheat starch).

Evening Meal
Clear broth + rice or vegetables.
Vegetable salad or vegetable stew.
Wheat starch bread and butter.
Fruit, if desired + sugar.

Important

During the day, one whole egg must be taken.*
e.g., If ½ egg is used in pudding, you can still take ½ egg with salad or ½ egg scrambled at another meal.
or Take one egg — boiled, fried, poached, or one egg as omelette or hard boiled in salad.
N.B. — Methionine 0.5 Gram, multivitamins t.i.d., and oral iron must be taken daily.

* Plus half an egg daily in addition for every 3 Grams of protein lost in the urine each day.

Notes on Renal Diet

Daily Allowance: 1½ oz. butter (sweet)
1 egg*
6½ oz. milk (measured carefully) for tea
Wheat Starch: Can be used for biscuits or pastry, and thickening gravy or fruit sauces.
Sugar: Can be used liberally.
Foods Forbidden: Ordinary flour in any form, meat, fish, cheese.

Recipe for Wheat Starch Bread:
1 lb. wheat starch (available as gluten free flour from Cellu Products Company)
10½ oz. water
1 oz. yeast
1 oz. sugar
2 oz. margarine/vegetable oil
Mix yeast with sugar. Warm special flour, rub in fat, add warm water. Mix to a soft batter consistency. Beat well. Pour into greased tins. Allow to stand in a warm place until it has risen to fill the tin. Bake at 450 to 500 Fahrenheit.

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9. GFR means glomerular filtration rate.

10. RPF is a symbol for renal plasma flow.

11. ADH stands for anti-diuretic hormone of the pituitary.

81 Wilder Street

Hypnosis Course

On four consecutive Saturdays, starting on January 7, 1967, you can participate in a course in hypnosis given by Herbert Spiegel, M.D. at the College of Physicians and Surgeons in New York. The tuition fee is $100. The course runs from 10 a.m. to 5 p.m. on every Saturday in January. For details and application forms, write to the Assistant Dean, College of Physicians and Surgeons, 632 West 168th Street, New York, New York 10032.

Not all that wheezes is asthma: even if the patient is an asthmatic.

Asthma Complicated by Bronchial Foreign Body

Elmer N. Mattioli, M.D./Vineland

A two-year old child had a history of having been treated by the family physician for a recent exacerbation of asthma. The child was a known asthmatic with increasing respiratory difficulty, wheezing and coughing for the past three weeks. Antihistamines and expectorants did not help him. The family physician then had a chest x-ray taken. This showed hyperaeration of the right lung and hypo-aeration of the left lung with a shift of the heart and mediastinal structures to the left side. The radiologist saw three possibilities here: (1) pulmonary atresia of the left pulmonary artery, (2) blockage or a mucous plug with some atelectasis of the left lung, or (3) foreign body.

The family doctor then questioned the mother about any possible foreign body. She recalled an incident which had occurred about four weeks previously. The child was eating peanuts when he suddenly started to choke. An older brother slapped him on the back. From that time on, the child was noted to have aggravation of his asthma with an increase in coughing and wheezing.

After getting the history and after examining this healthy-looking two-year old with generalized wheezing of both lungs, I made a diagnosis of foreign body of the left mainstem bronchus.

The patient was put on prophylactic antibiotics, and arrangements were made for bronchoscopy. Under general anesthesia, a 5 millimeter Reichert bronchoscope was inserted down the left mainstem bronchus. There was no foreign body there. The scope was then passed down the right mainstem bronchus, and there part of a peanut was found to be lodged. There was noted to be granulation tissue above the peanut and some beginning bronchial tapering. The peanut was removed by means of forceps. The procedure took about 20 minutes.

In retrospect, I see that this represented the typical radiologic picture of a foreign body not on the left side, but on the right side, with air being allowed to go into the right lung on inspiration but not being permitted to egress on expiration because of a ball-valve mechanism of the peanut.

The patient was re-rayed later the same evening, and a normal x-ray picture was demonstrated for the first time. On the third postoperative day, an alveolar pneumonitis was picked up on the x-ray of the chest. Two days later, this had completely subsided.

This case emphasizes the prime importance of making a diagnosis, since this type of lesion in a very young child may be overlooked. The history given by the mother concerning the foreign body was the important factor in making the diagnosis.

The mortality rate in neglected cases of this kind is high. There also are such complications as ulceration, erosion, empyema, or lung abscess.

The bronchoscopic procedure should not be continued beyond 20 minutes because of the possibilities of anoxia, cardiac arrest, or exhaustion. Utmost gentleness must be used in doing this procedure at this age, especially with a 5 millimeter scope, because of the possibility of laryngeal edema and occurrence of laryngeal obstruction necessitating emergency tracheotomy.

1300 East Landis Avenue

Here is a concise and practical guide to resuscitation of depressed newborns.

Resuscitation Of Depressed Newborns*

Some Clinical Considerations

Bradley E. Smith, M.D. and Frank Moya, M.D.

Miami, Florida

Depression of newborn infants requiring some degree of resuscitative therapy occurs in from 2 to 20 per cent of all births.[1] Severe depression may result in cerebral palsy or subsequent behavioral defects.[2] Even more frequently it leads to "hyaline membrane disease," or as it is now known "respiratory distress syndrome." This syndrome is one of the foremost causes of perinatal mortality. In fact, anoxia and pulmonary pathology are responsible for over 40 percent of perinatal mortality.[2]

Much of this morbidity and mortality can be prevented by prompt effective therapy or "resuscitation" from this depressed condition. The effectiveness of resuscitation depends upon a thorough knowledge of the inter-reaction of the respiratory center, the cardiovascular system, the lungs of the newborn infant, the acidosis resulting from prolonged asphyxia, and the depressant effects of anesthetic drugs. The physician must be prepared to act swiftly and in accordance with a carefully detailed and previously organized plan. He must possess a complete understanding of the available resuscitative equipment, and he should have examined it for proper function. He must be able to act in complete harmony with the other members of the Delivery Room team.

Asphyxia of the infant has often occurred before birth. This means an inadequate transfer of oxygen and elimination of carbon dioxide by way of the placenta and umbilical circulation, which may have been brought about by placental abruption, maternal hypoxia, maternal hypotension, compression of the cord, or other factors. Most babies (even apparently normal ones) have experienced some degree of asphyxia before birth. This asphyxia inevitably results in acidosis of the newborn. Instead of a normal 7.4 pH, the average vigorous baby with an Apgar score of 7 to 10 has a 7.2 pH; one with a score of 4 to 6 may be around 7.0 pH; and severely depressed babies with scores of 3 and less may have a pH as low as 6.8.[3] Left uncorrected, acidosis may result in cardiovascular depression and increased respiratory depression.

The newborn must initiate and maintain respiration not only to provide oxygen for the tissues, but also to eliminate the accumulation of carbon dioxide due to asphyxia, and thereby also reduce the acidity of the blood. This increased carbon dioxide normally *stimulates* respiration. But, in the severely asphyxiated newborn it actually *depresses* further the medullary center. In addition, the newborn soon after birth responds to hypoxia with a further decrease in ventilation.[2] All of these factors synergize with the well-rec-

* Read May 16, 1966 at Atlantic City before the Joint Session of Anesthesiology, Obstetrics, and Gynecology at the Annual Meeting of The Medical Society of New Jersey. This work is from the Department of Anesthesiology, Jackson Memorial Hospital, University of Miami School of Medicine. Dr. Moya is Chairman of that Department and Dr. Smith is Associate Professor.

ognized respiratory depressant effect of the anesthetic and analgesic drugs.

Perhaps equally important with these primarily respiratory problems are the less appreciated effects of inadequate ventilation on the unique and abrupt transition of the infant cardiovascular system from parasitic to independent existence. During fetal life, pressures in both chambers of the right side of the heart are higher than those of the left side. Blood, therefore, flows through the foramen ovale as well as the ductus arteriosus, largely bypassing the pulmonary artery.[4] With the expansion of the lungs, however, the resistance to flow through the pulmonary artery abruptly falls to less than a fifth of its former value.[4] Since the resistance to flow through the ductus arteriosus is then higher than pulmonary vascular resistance, blood begins to flow through the lungs. These changes in resistance and flow are due to the constrictive effect of blood oxygen above 55 millimeters partial pressure on the ductus arteriosus, the direct dilating effect of oxygen on the pulmonary arterial circulation, and the mechanical decrease in pulmonary resistance due to alveolar expansion.[4] Therefore, incomplete lung expansion or atelectasis can definitely lead not only to "shunting" of blood through unventilated alveoli (with improper oxygenation and carbon dioxide elimination) but also may lead to bypass of the lung by blood passing through a patent ductus arteriosus. This is a dangerous cycle of improper ventilation, hypoxia, and persistent fetal type circulation causing further hypoxia, hypercarbia, and acidosis, in turn, leading to further cardiovascular and respiratory depression. This cycle is almost identical to the pathophysiology of the "respiratory distress syndrome," in which as much as 60 percent of the cardiac output bypasses usable lung areas or shunts from right to left.[5]

The most effective therapy for newborn depression, therefore, rests on expansion of the lungs and reversal of this dangerous cycle. The three cardinal principles of resuscitative therapy are (a) immediate establishment of a patent airway; (b) prompt but gentle expansion and ventilation of the lungs (either through the infant's own efforts or by external means); and (c) continuous evaluation of the condition of the baby through the Apgar Score.

1. *Immediate Care.* Immediately after delivery, the infant's head should be placed lower than his feet. Prompt, brief, gentle aspiration of pharyngeal fluid should be carried out. After the umbilical cord is clamped, the baby is placed head-down, slightly on the side, in a warm receiving blanket in a prewarmed bassinette or resuscitation device. There should be a pad under the shoulders allowing the head and, with it, the airway to extend and straighten.

2. An airway should be immediately established and the baby allowed to breathe spontaneously for several seconds without interference from suction devices. If, within several seconds, respiration is not established, or seems inadequate, gentle stimulation of the baby should be carried out by flicking the feet or gently rubbing the baby.

3. At one minute the Apgar Score should be briefly calculated. This should take no longer than five seconds. Babies scoring "7, 8, 9, or 10" ("vigorous babies") ordinarily need little additional care. Babies scoring "4, 5, or 6" ("moderately depressed") should receive oxygen by mask, plus stimulation and, if necessary, oxygen by intermittent positive pressure breathing through the face mask. Care should be taken that the airway is patent and, if necessary, a Number 00 or 0 oral airway may be inserted to prevent airway obstruction by the flaccid tongue. Positive pressure should be as high as 35 to 50 centimeters of water for less than one-half second for initial inflation of the lungs. After the lungs are inflated, 15 to 20 centimeters of water suffice.

4. Babies scoring "0, 1, 2, or 3" ("markedly depressed") should have inspection and, if necessary, suction of the larynx and trachea, followed by immediate endotracheal intubation. The lungs should be inflated either with mouth-to-tube respiration or by positive pressure supplied by the mechanical resuscitator.

5. If the heart beat has disappeared within a few minutes of the delivery, external cardiac massage may be employed at the discretion of the resuscitator. (The possibility of neurologic residual in infants successfully resuscitated after prolonged periods of cardiac standstill should not be disregarded.) In such a case the infant should be quickly laryngoscoped, the pharynx suctioned, the trachea intubated, and the lungs expanded with oxygen. Almost simultaneously, the index and middle finger of the resuscitator's hand should be pressed sharply against the middle third of the baby's sternum at about 100 to 120 times per minute while the infant rests upon a hard surface. Effective blood pressures above 70 millimeters (of mercury) have been measured during this procedure.

6. *Drugs.* The older respiratory stimulants including Metrazol,® Alpha-lobeline,® and Coramine® should be avoided. Drug treatment in depression of the newborn should be directed toward correction of acidosis and support of the cardiovascular system, and the use of nalorphine or Levallorphan® in reversal of narcotic-induced respiratory center depression.

Levallorphan	0.05 mg. into the umbilical vein.
Nalorphine	0.2 mg. injected into the umbilical vein.
Epinephrine	0.05-0.1 mg. intracardiac after cardiac arrest.
Sodium bicarbonate	3.0-5.0 cc. of a 7.5% solution diluted to 10 cc. and given slowly into the umbilical vein.

Although some other methods of resuscitation which have been advocated (including hypothermia, hyperbaric oxygenation, rocking beds, and phrenic nerve stimulation) may merit further investigation, intra-gastric oxygenation and convulsant drug therapy clearly have no place in this field.

After successful resuscitation, the infant should be watched carefully for recurrence of the depression. Special care should be given to premature babies, those born by Caesarean section, babies with congenital anomalies, babies whose mothers were diabetic, or those who show indications for antibiotic or transfusion therapy.

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Jackson Memorial Hospital 33136

Academy's Scientific Sessions

The Academy of Medicine of New Jersey announces the following scientific sessions in December 1966.

Date and Hour	*Place of Meeting*	*Subject*
Dec. 13—9 p.m.	Elizabeth General Hospital	Portal Hypertension
Dec. 14—1 p.m.	Veterans Administration Hospital, East Orange	Psychedelic Drugs
Dec. 14—8 p.m.	Academy of Medicine, Bloomfield	Medical History
Dec. 14—10:30 a.m.	St. Mary's Hospital, Passaic	Gastrointestinal Malignancy
Dec. 16—11 a.m.	New Jersey Neuro-Psychiatric Institute, Princeton	Alcoholism
Dec. 17—9 a.m.	Orange Memorial Hospital	Epidural Anesthesia
Dec. 28—1 p.m.	St. Peter's Hospital, New Brunswick	Therapy of Lymphomata

For more details, write to The Academy of Medicine, 317 Belleville Avenue, Bloomfield, New Jersey.

From this survey it appears that school children often start smoking at the age of 8; and are sometimes "hooked" by the time they are 10 or 11 years old.

Cigarette Smoking In School Children

Paul H. Steel, M.D./Atlantic City

During the spring of 1965, the Medical Society of Atlantic County sponsored a survey of smoking by school children. Purposes of this investigation were: (1) to determine the extent of cigarette smoking in school children; (2) to find out why they smoked; and (3) to determine an avenue of attack on this habit which might be used in a follow-up educational program.

A questionnaire was prepared which called for simple one-word or true-false answers. With the cooperation of the Atlantic County school system, these one-sheet forms were distributed to every public and parochial school, grades 5 through 12 inclusive. The test was given over a five-day period, and the forms were not signed. Each teacher read an explanatory message. The papers were then distributed, answered, turned over on the desks, collected, and placed in an envelope and sealed.

Additional coding was done with the help of volunteers from local civic and welfare organizations.

Results were transferred to IBM punch cards. This was made possible through the cooperation of Prudential Life Insurance Company, Linwood, New Jersey. The cards were tabulated by the Data Processing Department of the Atlantic City Hospital.

Results

A total of 16,486 children in grades 5 through 12 took the test. Of these 8,075 were females. We found 1,996 males who are present or past cigarette smokers. This represents 24 per cent of the boys. The 1,506 female smokers represented 19 per cent of the girls. Thus, 21 per cent of these children smoked. There were, overall, only 41 boys and 21 girls who had stopped smoking. Out of 468 males in grades 5 through 8 inclusive, 195 would "like to stop smoking"; whereas, out of 254 females in the same group, 89 would like to stop. In other words, some 36 to 39 per cent of the juvenile smokers said that they wanted to stop the habit.

CHART 1

When Started Smoking

Age	Grade	Boys	Girls
8	3rd	156	35
9	4th	186	58
10	5th	263	130
11	6th	361	220
12	7th	389	294
13	8th	260	273
14	9th	156	245
15	10th	66	117
16	11th	16	64
17	12th	8	14
		1,861	1,450

As indicated in Chart 1, the modal age for starting to smoke was 12 (seventh grade) for both sexes. The median age, however, was 11 (sixth grade) for boys and 12 (seventh grade) for girls. In the third grade, boys outnumbered girl smokers five to one. By the ninth grade (age 14), 87 percent of the smoking boys had acquired the habit; for girls, the corresponding figure was 70 per cent (that is, 70 per cent had the habit by ninth grade). Among late starters (10th grade and above), girls outnumbered the boys.

The number of cigarettes smoked daily is shown in Chart 2.

CHART 2

Cigarettes Daily:	1	2–4	5–10	11–20	21 or more	Mode
Males—Grades 5–12	395	554	498	287	98	2 to 4
Males—Grades 5–8	278	251	131	48	29	1
Females—Grades 5–12	395	531	312	125	38	2 to 4
Females—Grades 5–8	197	142	49	11	9	1

Among boys, 78 per cent smoked 10 or fewer cigarettes a day; among girls, the figure was 88 per cent. In the lower grades, 89 per cent of the males and 95 per cent of the females smoked fewer than 10 a day.

Why did they start smoking? We still don't know — 75 per cent of the respondents just didn't answer this query. Those who did reply usually gave either of these answers: (a) "A feeling of accomplishment," or (b) "Influenced by a friend."

Next we asked: Does your best friend smoke? As indicated in Chart 3, there was a good correlation between the smoking of friends. If a boy smoked, then in 78 per cent of the instances, the best friend was also a smoker. For girls, the corresponding figure was 83 per cent, which suggested a greater "friendly influence" force among these young females. Among the nonsmokers, the best friend was a smoker in 15 per cent of the girls but 24 per cent of the boys.

CHART 3

Smoking Habits of Best Friends:
("Does Your Best Friend Smoke?")

	Smokers		Non-Smokers	
	Yes	No	Yes	No
Males—Grades 5–12	1477	392	1465	4502
Females—Grades 5–12	1205	241	1143	5105
Males—Grades 5–8	596	184	754	3076
Females—Grades 5–8	382	67	522	3509

The influence of a parent's habits on his (or her) children is clearly shown in Chart 4. If a child is smoking, the chances are five-to-one that his parents (or one of them) smoke.

CHART 4

Totals		Children Don't Smoke	Children Smoke
11,947	Parents Smoke	9,193	2,754
3,928	Parents Don't Smoke	3,313	615
15,875	Totals	12,506	3,369

The smallest number in Chart 4 is that for children who do smoke when their parents don't.

CHART 5

	Grades	("Do Your Like School?") No	Yes
Male Non-Smokers	5–12	1489	4460
Male Smokers	5–12	671	1182
Male Non-Smokers	5–8	955	2902
Male Smokers	5–8	307	474
Female Non-Smokers	5–12	939	5325
Female Smokers	5–12	421	1021
Female Non-Smokers	5–8	514	3574
Female Smokers	5–8	134	313

To give meaning to Chart 5, note that 75 per cent of nonsmoking boys liked school; for smoking boys, the figure was only 64 per cent.

Next we turned our attention to the nonsmokers and asked why. Their answers are displayed in Chart 6. The most popular single reason for abstinence was expense. If the reasons are grouped, the most common group of reasons is seen to be health. Parental influence did not seem to play as large a role as might have been anticipated.

CHART 6

Reasons For Not Smoking.
(Multiple answers are given multiple tallies)

Boys		Girls
1,216	Expense	1,080
734	Made sick by smoking	828
707	Fear of cancer	540
666	Bad for health	499
626	Bad taste of smoking	335
500	Didn't think it good for me	528
459	Parental influence	487

There was only occasional mention of religious, ethical, or athletic reasons.

Comment

It seems clear that there *is* a cigarette problem among children in grades 5 through 12 (ages 11 through 17) in schools. About one out of five smokes or has smoked cigarettes. Though smoking is widespread, there may be some comfort in the fact that the quantity

smoked is not heavy. About 83 per cent smoked 10 or fewer cigarettes per day. If a child has not smoked by his freshman year (ninth grade), chances are he will not develop the habit before high school graduation.

One of the discouraging facts was that there were only 2 per cent ex-smoking males and 1.3 per cent reformed smokers among the girls. Only 195 males, grades 5 to 8 (out of 807), and 89 females, grades 5 to 8 (out of 460), would like to stop smoking. This represented only 22 per cent of the sample.

If a child is not motivated to give up smoking, the chances are he will not. Motivation is related to proper education. A high ratio of the children who have given up smoking (or who never smoked) have cited health reasons as the motivating force. This is probably related to the vast educational programs, such as those conducted by the American Cancer Society, and other health groups. Since such information is getting through to a large proportion of these impressionable children, these educational efforts should be expanded. The natural place for dissemination of this education is the classroom.

Cigarette smoking first appears in grades as low as the third: 8-year-old children. These should be the targets of the attack. Each year a new crop of third graders arises. Obviously, then, the program must be on a continuing basis.

But the target must be dual: parents as well as children. Given a comprehensive educational exposure, the receptive parent would realize the danger smoking cigarettes poses for his or her children. They should also realize the strong position they maintain to discourage the habit. It may be impossible for the chronically "hooked" parent to discontinue smoking himself or herself; but by simple common sense action, children could be influenced so that the seeds for smoking are never sown. We believe that this program should be built around the medical hazards associated with cigarette smoking. The well-documented facts deserve emphasis over and over again, especially the relationship of cigarette smoking to cancers, respiratory ailments, gastrointestinal complications, and cardiovascular diseases.

Good could also be accomplished by making cigarette smoking less glamorous and less acceptable. For instance—and briefly—if parents must smoke, they should do so not in the company of their children. Public smoking should be discouraged, such as in public buildings and on public conveyances.

If any group of people should get this message, certainly physicians should. What is true for parents is true for doctors.

The Atlantic County Medical Society conducted informational school assemblies throughout the 1965-66 school year especially for grades 3 through 8. These were well received. Attention-arresting films were used, physician "truth teams" were available, and educational material was distributed to the homes.

Summary

A study of children in the Atlantic County schools, conducted in 1964-65 in grades 5 through 12, covering 16,480 students, indicated that:

1. Some 21 per cent of the school children have smoked cigarettes.
2. Boys usually started in grades 3 to 8 (ages 8 to 13).
3. Girls usually started in grades 5 to 10 (ages 10 to 15).
4. The most common reasons given by the children for *not* smoking were health and expense.
5. Parental smoking habits strongly influenced smoking by children.
6. A medically-centered, school-located educational program may be helpful in discouraging the habit.

2703 Pacific Avenue

This is the fourth of a series of articles on workmen's compensation and industrial rehabilitation in our state.

Rehabilitation Of The Disabled Worker

Supervision of Medical and Rehabilitation Service*

Jarvis Smith, M.D./Trenton

Ten years ago the International Association of Industrial Accident Boards and Committees said that: "Rehabilitation is the end result of the compensation process. If we compensation administrators fail to realize this important fundamental and are satisfied merely to sit back, to dole out to the injured workman a certain percentage of his wage according to our various laws, then the entire compensation process becomes archaic and outmoded." Similar views have been expressed by organized medicine, labor, management, insurance, compensation administrators, and attorneys — all of whom have endorsed rehabilitation as the primary objective of Workmen's Compensation. Yet, it is generally conceded that, too often the first step has not been taken: provision of high quality restorative medical services.

A number of reasons are given for this: inadequate fees, the reluctance of many employers and some carriers to pay for quality services, and the feeling (on the part of the claimant's lawyer) that the disability should loom as large as possible in order to obtain greater indemnity.

In the United States any licensed physician can legally perform *any* medical procedure regardless of the need for specialized training or experience to perform the procedure. There are, however, other safeguards which tend to elevate the quality of medical care. Facilities, professional societies, and financial intermediaries which serve as mechanisms for the payment of services all impose additional standards. In general, the accountability for medical care resides with the attending physician. In those instances where this function is assumed jointly by some other agency, that agency may not necessarily be primarily concerned with the claimant's welfare.

In those cases, for example, in which an insurance company assumes responsibility for the medical care provided a claimant, the incentive for quality stems from the very practical base that "good medicine pays." However, an insurance company is a business organization, not a philanthropic institution. Its primary responsibility is to its policyholders and, in the case of stock companies, also to its shareholders.

Despite all this, it is probably not an exaggeration to say that the insurance industry has contributed as much as any group to the elevation of the quality of medical care under Workmen's Compensation. However, insurance companies should not be expected to assume the role of arbiters of medical care and rehabilitation services under Workmen's Compensation.

Standards of quality cannot be achieved and maintained unless standards exist. Some single agency must be responsible for supervising those persons and agencies providing services to encourage them to meet the standards which should be established. Specifically, these are functions which the Workmen's Compensation agency should exercise, since they are the statutory bodies which have been assigned responsibility for administering the compensation program. There is far less agreement about the extent of the Workmen's

* An abstract by Jarvis M. Smith, M.D. — Medical Director, New Jersey Rehabilitation Commission—from the original monograph by Monroe Berkowitz, Ph.D.

Compensation agency's authority for the supervision of services and the way in which this authority should be exercised.

Responsibilities of the Division

In February 1960, the Regents of the American College of Surgeons adopted a policy statement entitled *The Basic Requisites for an Adequate Compensation System* developed by its Subcommittee on Industrial Relations. According to this statement, it was the duty of the compensation agency to supervise the medical care of the workmen's compensation cases. To do this it was necessary that each administrative agency of workmen's compensation have a medical staff to:

1. Review all reports of injury as submitted by the employer and attending physician.

2. Determine those cases which are to be called to his immediate attention; and in such cases to take steps:

(a) To determine accuracy of diagnosis.

(b) To assure that the injured worker is under competent medical care.

(c) After discussion with the attending physician, to consider whether there is need for consultation services.

3. See that competent and continuous medical care is provided as long as medically indicated.

4. Establish standards for the provision of medical and vocational rehabilitation and to see that such services are provided when and as long as indicated.

5. Examine all injured workers before any final financial determination of permanent disability is made by the agency, to make sure maxmium recovery has been obtained.

It goes without saying that such an administrative supervision of medical care presupposes an adequate medical staff which has available to it the information necessary to make the decisions indicated. A few years ago New Jersey's law was amended to provide that no determination of permanent disability need be made until twenty-six weeks had elapsed. This sort of rule is designed to carry out the objectives listed above: to see to it that the worker has attained maximum recovery before the financial determination of permanent disability is made. It was recognized at that time, that providing for a delay of an arbitrary number of weeks was not the ideal solution to the problem. It was a mechanical attempt to prevent premature evaluation of the disability. It would be far better to have this timing determined on a case-by-case basis in accordance with sound medical recommendation.

Staffing Problems

The Division of Workmen's Compensation today employs (part-time) ten physicians and has available to it, ten consultants: six orthopedists, one dermatologist, one neurosurgeon, one audiologist, and one ophthalmologist. It is not meant as a criticism of the existing administrative structure to point out that deficiencies may be present. The Regents of the American College of Surgeons stated in the document mentioned above that if the Workmen's Compensation Agency is to carry out its responsibilities for supervising medical care, it must have a medical department headed by a director well-versed in occupational accidents and diseases.

At present, supervision of medical care in New Jersey comes about almost as a by-product of other activities. In the "Direct Settlements Review program" it is necessary from time to time to inquire into the type of medical care being provided. Also, in referring a case for rehabilitation the adequacy of definitive medical care may come in for consideration. But what is a by-product in these procedures ought really to be at the heart of the concern of the Workmen's Compensation Division. For these purposes an adequately staffed and competent medical department is essential.

Medical Reporting

The worker does not have free choice of a physician in New Jersey. In the usual case, he is treated by a physician selected by the employer or carrier. The supervision of his medical treatment is in the hands of the carrier, if anyone. The Division does not receive medical reports from the physician as a routine matter. The Institute's panel contrasted this procedure with that in the State of New York and other jurisdictions where physicians routinely report their activity in connection with the compensation case.

Experience in New York State and in the disability determinations under social security has shown that with training, direction, and education, it is possible to achieve a high degree of cooperation between the medical profession and public agencies. This results not only in adequate medical reporting from the physician but also in his becoming aware of rehabilitation factors and long-range medical care.

The panel recognized that the first step in any rehabilitation program is the provision of definitive medical care and that it is not possible to separate medical care and other rehabilitation procedures. Too often persons think of rehabilitation merely as training or retraining. New Jersey has the tradition (which ought to be encouraged) of physical restoration. Retraining is used only when all else has failed, and the worker cannot be returned to his original job or employer.

Role of the Carrier

It is the responsibility of the Division to supervise medical care directly. In many cases, however, it is recognized that this must be done through the insurance carrier which has charge of selecting the physician and is the intermediary which pays his bills. Adequate medical audits of services provided would enable the Division to distinguish those carriers which are fulfilling their responsibility in this regard and those which are not. The Division of Workmen's Compensation and its medical section should have close contact with the local claims manager's counselor in order to provide a common understanding of the problems of medical care and rehabilitation. It must always be borne in mind that the insurance companies cannot be expected to assume the role of arbiters of medical care and the rehabilitation services under workmen's compensation. This is the responsibility of the Division of Workmen's Compensation.

Recommendations

1. The New Jersey Workmen's Compensation Division should have a full-time medical staff charged with the medical supervision and direction of medical matters.

2. The Workmen's Compensation Division should have available to it an advisory group of representatives of the major professions involved in medical care and rehabilitation. This group should help in the formulation of professional policy standards and procedures.

3. At an appropriate time after the accident or onset of illness, the treating physician should be required to submit a full medical report to the Division of Workmen's Compensation. Sufficient medical information ought to be provided so that the medical staff of the Division can evaluate whether adequate medical care is being provided and whether all is being done that should be done to provide for physical restoration and rehabilitation.

4. It is recognized that requiring such information from the treating physicians would be most successful if it is preceded by an educational campaign designed to show the medical profession the advantages of having this information available. Progress reports indicating current status of the case should be required at stated intervals.

5. The Division of Workmen's Compensation should have the legal right to obtain a thorough clinical review of cases where indicated.

6. The Division of Workmen's Compensation should cooperate with the insurance carrier and the physician in the interest of achieving maximum rehabilitation for the patient. However, in those few cases where it is necessary, the Division should have authority to transfer patients to another physician or facility if the individual does not seem to be making satisfactory progress.

7. Periodic medical audits should be conducted in selected cases to obtain information as to the adequacy of care provided by the program in general. Statistics should be compiled which will include data on the medical aspects of the program.

John Fitch Plaza

STATE ACTIVITIES

Trustees' Minutes

October 16, 1966

A regular meeting of the Board of Trustees was held on Sunday, October 16, 1966, at the Executive Offices. For your full information, detailed minutes are on file with the Secretary of your component society. A summary of the significant actions follows:

The "Irresponsibility Defense" Bill . . .agreed to take no action on A-355 — the "Irresponsibility Defense" Bill — because it involved many considerations concerning which MSNJ is not in position to take a justifiable stand.

AMA Congress on Socio-Economics of Health Care . . . designated the following to represent MSNJ at the AMA First National Congress on Socio-Economics of Health Care, to be held at the Palmer House in Chicago on January 22 and 23, 1967:

Joseph R. Jehl, M.D., President
Joseph P. Donnelly, M.D.
Nicholas E. Marchione, M.D.
Richard I. Nevin, Executive Director

Increase in Rehabilitation Fee . . . heard from the New Jersey Rehabilitation Commission that the fee for basic medical examination and report for the vocational rehabilitation program has been increased from $7.50 to $10.00.

Current State Legislation . . . adopted the positions recommended by the Council on Legislation, as indicated on the following bills:

All bills thus marked (*) are identical with measures of last year — or preceding years — whose positions were the same.

*S-359—To make certain technical amendments in the
*A-648—act concerning mentally retarded persons. (S-359 is LAW, CHAPTER 82) *Approval*

S-367—To require that containers of pasteurized milk or cream be marked with the date on which they were pasteurized or with the ending date of the 24-hour period during which they were pasteurized. *No Action*

S-402—To direct the Department of Institutions and
A-781—Agencies to determine a plan for medical assistance for the needy in accordance with social security programs providing OAA, aid to the blind, aid to dependent children, and aid to the disabled. *Approval*

S-410—To provide as a disorderly person anyone who, having reason to believe he is affected with tuberculosis, appears in public and knowingly subjects another to exposure to the infection of the disease. *Disapproval* . . . because this is an impractical amendment to an impractical existing statute and is neither necessary nor conducive to the betterment of the public health.

S-443—To authorize the New Jersey Medical and Dental College Board of Trustees to sell or lease any land or existing dormitories to the New Jersey Educational Facilities Authority in order to provide new dormitories or any additions or improvements thereto. (LAW, CHAPTER 110) *Approval*

S-486—To establish motorcycle safety requirements. *Approval*

S-487—To exempt from provisions of the sales tax, the sale of artificial limbs, eyes, hearing devices, teeth, and eye-glasses. *Approval*

S-489—To require all persons operating a motorcycle to wear a protective helmet, goggles, or a face shield; and to require all motorcycles to be inspected annually. *Approval*

S-492—To provide that the procurement, processing, or distribution of blood and tissues for the purpose of injecting, transplanting, or transfusing is declared to be the rendition of a service by every person participating therein and is not a sale. *Approval*

S-494—To appropriate $1,500,000 for the purposes of acquiring land and of providing for architectural and engineering design and planning for the New Jersey College of Medicine and Dentistry. *Approval*

A-11 —To provide for a program for control of depressant and stimulant drugs and the commitment and treatment of drug addicts by establishing a State Narcotic Control Commission. *Action Deferred* . . . pending study and report.

It was the opinion of the Legislative Analyst that this measure would not move in this legislative session (1966), but would probably be introduced and acted upon early in the 1967 session. Because of the formidable length of

the bill, the council agreed — since time would permit — that two members could review it in detail and report back at the next meeting. The council likewise agreed that it would be helpful to have the remarks and opinion of the New Jersey Pharmaceutical Association and of the State Narcotic Control Commission concerning this legislation.

The Board unanimously agreed that it would be helpful also to have a study of the experiences which New York has had with similar legislation. The Board, therefore, amended the action of the council — upon motion by Dr. Greifinger, seconded by Dr. Collins, and carried — to include a study by the council of the experience New York has had in this area with its similar legislation.

A-640—To require (1) every employer of 75 or more employees to provide adequate medical care or attention for injuries arising out of, and in the course of, such employment; (2) a registered nurse on the premises of employers having fewer than 200 employees; (3) where 200 or more are employed, the presence of a licensed physician at all times such employment is in operation. *Disapproval* . . . because, although the declared purposes of the bill are commendable, the stipulated requirements are impossible of fulfillment in view of the limited number of nurses and practitioners in New Jersey.

A-661—To expand the Good Samaritan Act to include immunity from civil damages liability for all persons who extend emergency aid. *Disapproval* . . . because it would expose victims of accidents to serious danger in consequence of well-meant but incompetent ministrations that could do more harm than good.

*A-683—To create a "Practicing Psychology Licensing Act." (Substantially the same as S-325 of 1966, which is now law — Chapter 282.) *Active Opposition* . . . because it invades the Medical Practice Act and assigns to unqualified lay-individuals functions which they are not licensed or qualified to fulfill by permitting them to practice psychotherapy.

A-689—To authorize the Commissioner of Banking and Insurance to approve for inclusion in contracts of a hospital service corporation benefits for other related health care services than hospital services. (LAW, CHAPTER 125) *Approval,* in support of the position of Hospital Service Plan of New Jersey.

A-721—To prohibit motor vehicles from operating on public highways unless equipped with tires in safe operating condition in accordance with requirements approved by the Director of Motor Vehicles and to set forth unsafe conditions. *No Action*

A-743—To regulate the transportation, sale, and handling of dogs, cats, and other animals intended to be used for purposes of research or experimentation, and for other purposes; effective 30 days after enactment. *Disapproval* . . . because, at national level, legislation has recently been enacted which renders state legislation unnecessary.

A-761—To remove ophthalmic technicians from the regulatory provisions of the act governing the practice of ophthalmic dispensing. *No Action* . . . unless the Society is asked for specific support from the New Jersey Guild of Prescription Opticians.

The council discussed its position of 1958, when identical legislation was introduced. At that time, the New Jersey Guild of Prescription Opticians requested the support of MSNJ in their efforts to defeat the measure. Since the Guild has not solicited the Society's assistance in opposing A-761, the council agreed a position of "no action" was all that was indicated. However, if specific request is made to MSNJ from the Guild to support a position of opposition, the council *recommended* that MSNJ's position on A-761 be that of "disapproval . . . because it would weaken the present law and would impair the adequacy of protection presently afforded the general public without accomplishing any appreciable substitute."

A-780—To increase the number of State competitive scholarships awarded annually to 6% (in place of 5%) of the graduated students. *Approval*

A-905—To provide that no person shall deliver to any consumer potable water which does not conform to the standards of the State Department of Health, established by regulation; to place in the Health Department supervision of all water supply systems with respect to the quality, protection, and maintenance of adequate pressure and volume of the supply of potable water furnished. *Approval*

"Clean Air Week" . . . approved the recommendation of the Air Pollution Control Committee that MSNJ support the Governor's proclamation designating "Clean Air Week" (October 23-29).

Air Pollution Conference . . . approved recommendation of the Air Pollution Control Committee that Dr. Rosalyn Barbash of Teaneck officially represent MSNJ at the National Conference on Air Pollution to be held in Washington, D.C. on December 12, 13 and 14, 1966.

Eye Health Screening Program . . . approved the recommendation of the Conservation of Vision Committee as follows:

(1) That, with the cooperation of the New Jersey Commission for the Blind and the New Jersey College of Medicine and Dentistry, the principle and procedures of MSNJ's annual eye health screening program be applied to the conduct of mobile-unit-centered, year-round screening procedures.

(2) That MSNJ, in support of the project, endorse the submission by the New Jersey College of Medicine and

Dentistry of a grant application to the Federal government.

Golden Merit Award Ceremony . . . approved the following recommendations of the Council on Public Relations concerning the 1967 Golden Merit Awards ceremony in Atlantic City:

(1) That the conferral ceremony be scheduled for 2:00 p.m. in the Rutland Room; that the Derbyshire Lounge be ready for service at 2:00 p.m. and staffed at 2:30 p.m.

(2) That a group picture be taken as well as individual pictures, preferably in advance of the official ceremony.

(3) That county group pictures be taken in those instances where more than one recipient is present from the same county, preferably in advance of the official ceremony.

(4) That two photographers be available in the Rutland Room following the official ceremony, to accommodate — at their own expense — those recipients desiring private family photographs.

Annual Meeting . . . approved the following recommendations of the Annual Meeting Committee:

(1) That the final program for the 1967 Annual Meeting (distributed in Atlantic City) be dedicated to the memory of Mrs. Edith L. Madden, former Administrative Secretary and Convention Manager.

(2) That the same type badge holder be used in 1967 as was used in 1966 (size 2½" x 4", with clip for the gentlemen and pin for the ladies).

Disaster Hospitals . . . approved the following recommendations of the Disaster Medical Care Committee:

(1) That effective liaison be established between MSNJ, civil defense organization, Army Medical Reserve, and National Guard, so that these units may be employed at the time of national disaster for the erection of the packaged disaster hospital.

(2) That a state-paid nucleus for the packaged disaster hospitals be established at state level, for the purpose of establishing hospitals at the scene of disaster.

JOURNAL Cover . . . approved the recommendation of the Publication Committee that a new cover design be instituted with the January 1967 issue of THE JOURNAL, at which time the JOURNAL's special bicentennial cover will be retired.

JOURNAL Staff . . . approved the reorganization of the JOURNAL office staff and the delineation of duties for the Editor, Editorial Secretary, and Advertising Manager.

Over "65" Welfare Recipients . . . approved the contents of the letter sent by the Board Chairman to the Ocean County Medical Society concerning the Board-approved (August 21, 1966 meeting) program for new coverage of over "65" welfare recipients:

The Board of Trustees met on September 18, so your letter of September 23 — in which you urge reconsideration by the Board of the approved proposal of the New Jersey Division of Public Welfare to utilize the principles and mechanisms of Part B of Title XVIII (Medicare) to compensate for professional medical services rendered to welfare recipients over 65 years of age — arrived too late for the Board's attention.

However, you will be pleased to know that before formally adopting the minutes of its meeting of August 21, the Board reviewed its actions in the area of interest which you point out. After some discussion, the Board unanimously decided that the action was sound and should stand, and that no alteration of the minutes should be made.

With reference to paragraph #4 of page 59, you report that it is the sentiment of the Ocean County Medical Society that the declaration, "For all such welfare clients over 65 years of age dealt with under this proposal, physicians will accept an assignment," deprives the physician of his right to bill directly.

The important words in the quoted passage are "dealt with under this proposal." These are welfare patients that are involved. They have no money, and that is why they have been placed on welfare. Hitherto, professional services rendered to them in hospitals have been rendered gratis. Now, "under this proposal," the Division will pay for such services on the basis of 80% of the physician's customary and reasonable fee, including the first $50 — which you are aware is a deductible in the case of the regular recipient under Part B. So under this program our physicians are given an advantage as to the deductible which they will not enjoy for non-welfare beneficiaries under Part B. The program also eliminates the requirement that a physician receive permission from the Welfare Board to treat the patient a given number of times and at a fixed welfare fee.

There is nothing in the proposal that abrogates the physician's right not to render service to individuals who are such welfare patients; nor is he obliged to acquiesce in the proposal. If he doesn't choose to work "under this proposal" but does decide to render service to welfare patients over 65, he is free either not to charge them at all, or to bill them individually and try to collect. Only if he chooses to work "under this proposal" must he take an assignment, otherwise "under this proposal" he would not be paid.

We find nothing on page 59 of the August 21 minutes which invades or interferes with the patient's free choice of physciian. The patient calls for or upon the doctor. If the doctor accepts the patient and the patient is eligible for the proposed coverage, then the Welfare Division will, if the doctor accepts an assignment, pay for the service rendered on the terms in-

dicated for services billed for on the "regular and customary fee-for-service basis."

Where physicians previously worked for nothing, now they can, if they will, receive 80% of carrier-approved regular and customary fees. Obviously, the compensation is not to be 100%, but that is because the Part B Medicare coverage whose pattern is being used does not pay on a 100% basis but on the basis of 80% — less the initial deduction which this proposal will cover though Part B Medicare does not.

The Board regards the proposal as sound, fair, and equitable and on that basis has agreed to it for the benefit of all our members who wish to use it.

Industrial Safety Board . . . received notification from Governor Hughes of his appointment to membership on the Industrial Safety Board of Joseph A. Lepree, M.D. of Elizabeth.

Selective Service System . . . directed that the following information be supplied to the AMA:

At the request of the Board, MSNJ's Chairman of the New Jersey Advisory Committee to the Selective Service System investigated possible inequities in the operation of the Selective Service System in the drafting of physicians from New Jersey. He reported that thorough investigation indicated that, although examples of faulty performance have appeared in other states, none of significance has been identified in New Jersey.

Conference with County Presidents . . . met informally with a total of twenty County Presidents and/or Presidents-Elect, representing eighteen Counties, whose newly elected Chairman (Dr. Roy T. Forsberg, President-Elect of Union County Medical Society) reported in behalf of the group as follows:

The group had informally discussed many items — all of which must be studied and evaluated by the individual counties. Some of the areas covered were: (1) programs at local level under the sponsorship of county committees on medicine and religion; (2) caliber of the annual meeting; (3) proposed revision of the Constitution and Bylaws in the interest of more equitable representation; (4) Medicare — Part B; (5) the role of county societies in helping organized medicine assume leadership with respect to health care services; (6) the relationship of Medical-Surgical Plan with physicians of New Jersey and MSNJ; (7) the physician's responsibility in influencing the decisions and policies of government at all levels; (8) the Relative Value Scale; (9) Title XIX of the Medicare Law.

The conferees were enthusiastic in their reception of the presentation of Mr. Arne Larson, Assistant Director of the AMA Department of Medicine and Religion.

The Board exchanged questions and answers with the group. Of special concern to some of the counties was the Board's action (August minutes, pages 58-60) in approving the recommendation of the Council on Medical Services concerning acceptance of the proposal from the Division of Public Welfare.

The Board reviewed Resolution #18 from the 1966 House of Delegates. Counsel was asked to make a declaration as to whether or not the action of the Board was in disregard of the principle of the resolution. Legal Counsel declared — as Parliamentarian and Counsel to MSNJ and to the Board — that there was no conflict between the two actions. Under the proposal of the Division of Public Welfare approved by the Board, physicians are free to bill "on their usual and customary fee-for-service basis" — as provided in Resolution #18. Whether or not physicians choose to accept the assignment of the Division of Public Welfare for reimbursement on the basis of 80% of their total bill is a matter of individual choice which each physician must make for himself. The compensation under the proposal takes full advantage of the subsidization available under Part B of Medicare, and adds payment of 80% of the deductible ($50) which Part B imposes. Moreover, it eliminates the requirement that physicians obtain permission to render repeated services to the covered welfare clients.

The group accepted as completely satisfactory the Board's explanation and the declaration of Legal Counsel.

Academy of Medicine of New Jersey

NEW LIBRARY ACQUISITIONS — FALL 1966

The Library of the Academy of Medicine of New Jersey, 307-17 Belleville Avenue, Bloomfield, announces the following acquisitions:

Basic Sciences

Baker, F. J., Silverton, R. E., and Luckcock, E. D. Medical laboratory technology. 4th ed. Wash., D.C., Butterworths, 1966.

Herms, W. B. Medical entomology, rev. by M. T. James. N.Y., Macmillan, 1965.

Horsfall, F. L. and Tamm, I., eds. Viral and rickettsial infections of man. 4th ed. Phila., Lippincott, 1965.

Stern, H. and Nannay, D. L. N.Y., Wiley, 1965.

Wilson, G. S. and Miles, A. A. Topley and Wilson's Principles of bacteriology and immunity. 5th ed. Baltimore, Williams & Wilkins, 1964. 2 vols.

Cardiovascular System

Brest, A. N. and Moyer, J. H. Cardiovascular drug therapy. N.Y., Grune & Stratton, 1965.

Gross, F. Antihypertensive therapy. Berlin, Heidelberg, N.Y., Springer, 1966.

Handbook of physiology, F. Hamilton and P. Dow. Wash., D.C., American Physiological Soc., 1963.

Hurst, J. W. and Logue, R. B. Heart, arteries and veins. N.Y., McGraw-Hill, 1966.

Orbison, J. L. and Smith, D. E. Peripheral blood vessels. Baltimore, Williams & Wilkins, 1963.

Orkin, L. R. Management of the patient in shock. Phila., Davis, 1965.

Selzer, A. Heart; its function in health and disease. Berkeley, Univ. California Press, 1966.

Zweifach, B. W. Annotated bibliography on shock, 1962-64. Wash., D.C., National Research Council, 1966.

Geriatrics

Freeman, J. T. Clinical features of the older patient. Springfield, Ill., Thomas, 1965.

Kurtz, R. H., ed. Manual for homes for the aged. N.Y., Federation of Protestant Welfare Agencies, 1965.

History of Medicine

Baker, R. The first woman doctor: . . . Elizabeth Blackwell, M.D. N.Y., Julian Messner, 1944.

Caldwell, G. A. Early history of the Ochsner Medical Center. Springfield, Ill., Thomas, 1965.

Davis, N. S. History of the American Medical Association to 1855. Phila., Lippincott, 1855.

Illinois. University. College of Medicine. Davis Memorial essays on the history of medicine. Chicago, Univ. of Illinois, 1965.

Marti-Ibanez, F., ed. History of American medicine. N.Y., MD Publications, 1959.

Miller, G., ed. Bibliography of the history of medicine in the United States and Canada, 1939-1960. Baltimore, John Hopkins, 1964.

Sturtevant, A. H. History of genetics. N.Y., Harper & Row, 1965.

Hospitals

American Acad. of Gen. Practice. Manual on general practice departments in hospitals. Kansas City, Mo., 1966.

Curry, G J. Immediate care and transport of the injured. Springfield, Ill., Thomas, 1965.

Schneewind, J. H., ed. Emergency service manual. Chicago, Year Book, 1963.

Yeager, M. E. Operating room manual: a guide for O.R. personnel. N.Y., Putnam, 1965.

Medicine

Blanton, W. B. Manual of normal physical signs. St. Louis, Mosby, 1926.

Cope, Z. Early diagnosis of the acute abdomen. 13th ed. N.Y., Oxford, 1965.

David, H. Submicroscopic ortho- and pathomorphology of the liver. Oxford, Pergamon, 1964.

Ingelfinger, F. J., Relman, A. S., and Finland, M. Controversy in internal medicine. Phila., Saunders, 1966.

Magraw, R. M. Ferment in medicine . . . the essence of medical practice. Phila., Saunders, 1966.

Stanbury, J. B., Wyngaarden, J. B., and Frederickson, D. S. Metabolic basis of inherited disease. 2nd ed. N.Y., McGraw-Hill, 1966.

U.S. Dept. of Health, Education, Welfare. Federal financial aid for the development of medical care facilities. Wash., D.C., GPO, rev. 1966.

Neurology

Burn, J. H., Autonomic nervous system, 2nd ed. Oxford, Blackwell, 1965.

Indiana State Board of Health. Home care of the "stroke" patient. Indianapolis, 1962.

Palumbo, L. T. Disorders of the autonomic nervous system. Chicago, Year Book, 1955.

Rappaport, S. R. Childhood aphasia and brain damage. Narbreth, Pa., Pathway School, 1964.

Smith, Kline, and French. The Neurologic examination. Phila., 1962.

Walshe, F. Diseases of the nervous system. 10th ed. Baltimore, Williams & Wilkins, 1963.

Nursing

Anderson, B. E. Nursing education in community junior colleges. Phila., Lippincott, 1966.

Fleming, M. O. and Benson, M. C. Home nursing handbook. Boston, Heath, 1966.

Meltzer, L. E., Pinneo, R., and Kitchell, J. R. Intensive coronary care—a manual for nurses. Phila., CCU Fund, Presbyterian Hospital, 1966.

National League for Nursing. Nursing in community mental health and retardation programs . . . N.Y., Nat. League for Nurs., 1965.

Ohio. Dept. of Health. Div. of Nursing. Guide for nursing practice at home and in nursing homes. N.Y., Nat. League for Nurs., 1965.

Red Cross. United States. Home nursing textbook. 7th ed. N.Y., Doubleday, 1963.

Obstetrics and Gynecology

Pincus, G. Control of fertility. N.Y., Academic Press, 1965.

Ciba Foundation Symposium. Preimplantation stages of pregnancy. Boston, Little, Brown, 1965.

Drill, V. A. Oral contraceptives. N.Y., McGraw-Hill, 1966.

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Allen, J. H. May's Manual of diseases of the eye. 23rd ed. Baltimore, Williams & Wilkins, 1963.

Fonda, G. Management of the patient with subnormal vision. St. Louis, Mosby, 1965.

New Orleans Academy of Ophthalmology. Transactions. Symposium on surgery of the ocular adnexa. St. Louis, Mosby, 1966.

New Orleans Academy of Opthalmology. Transactions. Symposium on infectious diseases of the conjunctiva and cornea. St. Louis, Mosby, 1963.

Orthopedics and Rehabilitation

American College of Surgeons. Emergency care of the sick and injured. Phila., Saunders, 1966.

Beetham, W. P., Polley, H. F., Slocumb, C. H., and Weaver, W. F. Physical examination of the joints. Phila, Saunders, 1965.

Goodman, F. and Schoedinger, G. Questions and answers in orthopedics. St. Louis, Mosby, 1966.

Mennell, J. M. Joint pain; diagnosis and manipulative technics. Boston, Little, Brown, 1964.

Rusk, H. A. A textbook on physical medicine and rehabilitation. 2nd ed. St. Louis, Mosby, 1964.

Rydell, N. W. The femoral head-prosthesis. Goteborg, Sweden, 1966 (Thesis-Univ. Goteborg)

Otorhinolaryngology

Levin, N. M., ed. Voice and speech disorders; Springfield, Ill., Thomas, 1962.

Schuknecht, H. F. Mastoidotympanoplastic surgery. St. Louis, Mosby, 1966.

Pediatrics

Cornblath, M .and Schwartz, R. Disorders of carbohydrate metabolism in infancy. Phila., Saunders, 1966.

Freud, A. Normality and pathology in childhood; assessments of development. N.Y., International Univ. Press, 1965.

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Newton, N. Family book of child care. N.Y., Harper & Row, 1957.

White, R. R. Atlas of pediatric surgery. N.Y., McGraw-Hill, 1965.

Pharmacology and Pharmacy

Deno, R. A. Profession of pharmacy. 2nd ed. Phila., Lippincott, 1966.

Fishbein, M. Modern home remedies and how to use them. N.Y., Doubleday, 1966.

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Alcock, T. Rorschach test in practice. Phila., Lippincott, 1963.

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Andrews, G. and Harris, M. Snydrome of stuttering. London, Spastics Society Medical Education Unit, 1964.

Bergler, E. Parents not guilty of their children's neuroses. N.Y., Liveright, 1964.

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Campanelle, T. C. Counseling parents of mentally retarded children. Milwaukee, Bruce, 1965.

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Ciba Foundation symposium. Transcultural psychiatry. Boston, Little, Brown, 1965.

Frank, L. K. and others. Personality development in adolescent girls. Yellow Springs, Ohio, Antioch Press, 1953. (Monog. of the Soc. for Res. in Child Develop., v. 10, ser. 53, 1951)

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Krech, D and Crutchfield, R. S. Individual in society. N.Y., McGraw-Hill, 1962.

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Nunnaly, J. C., Jr. Tests and measurements. N.Y., McGraw-Hill, 1959.

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White, R. W. Abnormal personality. 3rd ed. N.Y., Ronald, 1964.

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201st ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY

May 13-17, 1967
Haddon Hall, Atlantic City

Tentative Program

Friday, May 12, 1967

3:00 p.m. — Convention Office and Press Room Open
5:00 p.m. — Board of Trustees
7:00 p.m. — Board Buffet Dinner

Saturday, May 13, 1967

10:00 a.m. — Registration Opens
2:00 p.m. — Golden Merit Award Ceremony and Reception
4:00 p.m. — House of Delegates to be followed by MSP Discussion
7:00 p.m. — Officers Dinner
9:00 p.m. — Nominating Committee

Sunday, May 14, 1967

All Day — Installation of Exhibits
11:00 a.m. — Meetings of Reference Committees
2:30 p.m. — House of Delegates
6:00 p.m. — Reception for President-Elect

Monday, May 15, 1967

9:00 a.m. — Exhibits open
9:30 a.m. — Scientific Programs of MSNJ Sections
2:00 p.m. — Scientific Programs of MSNJ Sections
7:00 p.m. — Annual Dinner-Dance

Tuesday, May 16, 1967

9:30 a.m. — House of Delegates
9:30 a.m. — Special Scientific Programs of the Academy of Medicine/State Departments
1:00 p.m. — House of Delegates Luncheon
1:30 p.m. — House of Delegates Reconvenes
2:00 p.m. — Special Scientific Programs of the Academy of Medicine/State Departments
6:00 p.m. — Reception-Buffet Dinner for Tech. Exh.

Wednesday, May 17, 1967

9:00 a.m. — Board of Trustees
9:30 a.m. — Scientific Programs of MSNJ Sections
3:00 p.m. — Exhibits and Registration Close

OBITUARIES

Dr. Leon J. Camche

While on a cruise ship on October 2, 1966 Dr. Leon J. Camche of Irvington died suddenly, presumably of a coronary attack. Born in Russia in 1892, Dr. Camche was brought to this country as a child and attended the University of Pennsylvania, receiving his M.D. from that medical school in 1916. He went in the United States Army in 1917; and on being demobilized, came to Newark where he practiced in the Weequahic section until his retirement in 1964. Dr. Camche was a general practitioner affiliated with the Newark Beth Israel and Irvington General Hospitals.

Dr. J. Kenneth Catlaw

On October 13, 1966, at the untimely age of 55, death came to Dr. J. Kenneth Catlaw, a well-known Hudson County physician. Born in Brooklyn in 1911, Dr. Catlaw earned his M.D. at Belleview in 1937. He did graduate work in surgery and became a Fellow of the American College of Surgeons. He was active at both the Jersey City Medical Center and at the St. Francis Hospital, serving in many positions in the surgical service, and eventually becoming director of surgery at St. Francis. He was an official of the New Jersey Society of Surgeons, and active in the affairs of the Hudson County Medical Society.

Dr. Daniel F. Featherston*

A 1922 graduate of Bellevue, Dr. Daniel F. Featherston was one of Monmouth County's best known surgeons. He served his county medical society in almost every capacity and, for the past six years, he had been Treasurer of The Medical Society of New Jersey. He was an active member of the State Board of Medical Examiners. In his boyhod in Asbury Park, he was a newspaper reporter, a high school athlete (football and pole vaulting), and an important member of Dartmouth College's class of 1919. He was an FACS and active in our state's Society of Surgeons. He was attending surgeon at both Monmouth Memorial and Fitkin, and senior surgical consultant at the State Hospital in Marlboro. He was an active participant in many phases of civic, religious, and medical life in Monmouth County. Dr. Featherston died suddenly on October 30, 1966, at the age of 70.

Dr. Thomas Pastras

At the untimely age of 45, Dr. Thomas Pastras, a Camden County dermatologist, died on September 24, 1966. A 1946 Jefferson graduate, he had been elected to Alpha Omega Alpha while in medical school, had served in the Army Medical Corps during World War II, and was a board diplomate in dermatology. Dr. Pastras was active on the staffs of both Our Lady of Lourdes Hospital and the Cooper Hospital in Camden.

Dr. Elmer Peter Weigel

On November 8, 1966, Dr. Elmer P. Weigel, a well-known New Jersey orthopedic surgeon, died at the Muhlenberg Hospital in Plainfield, where for years he had been chief of staff.

Born in Buffalo in 1891, he received his M.D. at the University of Buffalo in 1914 and came to New Jersey in 1922. He was a pioneer in orthopedics and for some time headed up the orthopedic section of the New York Academy of Medicine. He was a president of the State Board of Medical Examiners, a diplomate of the American Board of Orthopedics, and for many terms served New Jersey as a member of the AMA House of Delegates. He was president of the Union County Medical Society, of the New Jersey Society of Surgeons, of the Plainfield Rotary Club, of the Plainfield Board of Education, and of many other organizations.

Dr. Weigel was active in civic affairs, and was on active duty in the Army Medical Corps during World War I.

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* For editorial comment on Dr. Featherston, see page 541 of this JOURNAL.

BOOK REVIEWS

Your Heart Has 9 Lives. Alton Blakeslee and Jeremiah Stamler, M.D. Pocket Books, Inc., April 1966. 278 Pp. Illustrated. (75¢)

This book is an attempt by a science fiction writer and a physician to present the story of coronary artery disease to the public. The title of the book is derived from the nine factors causing coronary atherosclerosis which the authors dramatically refer to as "conspirators" and "members of a syndicate." These are high cholesterol, hypertension, overweight, diabetes, overnutrition, lack of physical activity, excess smoking, tension and stress, and hereditary.

In a scholarly manner, Mr. Blakeslee and Dr. Stamler show how these factors have been implicated by numerous clinical and experimental studies. The major portion of the book is devoted to cholesterol and overnutrition and their relation to heart attacks.

Throughout the book, emphasis is placed on how these factors can be controlled. The authors agree that final proof has not been achieved on any of the factors. However, they stress that control of them will lead to a significant decrease in the incidence of heart attacks. Low cholesterol and polyunsaturated fat diets are presented in detail.

The book is well written and maintains the reader's interest. Accurate descriptions are given of the heart itself, coronary occlusions, and the treatment of heart disease. The book does a service to the general public by defining heart attacks and their consequences in a readable manner and by clearing the confusion surrounding the cholesterol question. The changes in our way of life regarding food habits, smoking, and physical fitness may be more difficult to achieve than the authors suggest. MARTIN CASTELBAUM, M.D.

Drugs of Choice: 1967. Edited by Walter Modell, M.D. St. Louis, 1966, Mosby. Pp. 968. ($16.75)

As the jungle of new drugs continues to grow, the physician is more and more in need of some kind of compass. This is the function admirably served by the current edition of "Drugs of Choice." The reader turns to the section of interest to him. For example, he can find a chapter on diuretics. Or there is another section on drugs and nutritional disorders, and another on local antiseptics, and so on. In each case, there is a list of these drugs and of the contraindications, complications, and dosage. Both the generic and trade names are used. One feature of the book (extremely well received in previous editions) is the drug list arranged in alphabetical order on green paper so that it is easily picked out. This is alphabetized both by trade name and generic name. If, for example, you know the drug is Dilantin but want to know the trade name, you simply look up Dilantin in the drug index and you are told what the generic name is. Contrarywise, if you know that someone has reported good results with tolbutamide, a quick look at the index will show you that tolbutamide is merely the generic name for the drug more familiarly known under the tradename of Orinase. Finally, the book is provided with an extensive and excellent alphabetical index not only to drugs but also to drug actions. This is a handy volume for any doctor to have on the shelf in his office, and it will soon earn its keep. VICTOR HUBERMAN, M.D.

Stereoscopic Atlas of Mastoidotympanoplastic Surgery. H. F. Schuknecht, M.D., W. D. Chasin, M. D., and J. M. Kurkjian. St. Louis, 1966, Mosby. Pp. 92. Illustrated. ($26.50)

The adage "one picture is worth a thousand words" is amply demonstrated in this new book. This volume represents the surgical procedures recommended by Dr. Schuknecht and his colleagues in the treatment of chronic suppurative disease of the middle ear and the mastoid.

This small book, costing $26.50, consists of 92 pages, 51 illustrations, and ten reels of stereoscopic slides. Enclosed also is a slide viewer. In this small volume there is an immense amount of material. The authors do not go into controversy concerning the procedures by other surgeons over the country. This is, of course, an asset to the book. The text starts with indications and contraindications for surgery. Any surgeon who follows their advice will make no serious mistake in presenting patients for surgery and in denying others surgical treatment.

There is a chapter on the histopathology of chronic otitis media and chronic disease of the middle ear and mastoid. In 30 pages the authors cover thoroughly, and adequately, all that is really known to date concerning this subject.

Chapter III describes the technic of mastoidotympanoplastic surgery which this group has found satisfactory. The description is accompanied by slides that beautifully illustrate the step-by-step surgery described in narrative form.

One short chapter is devoted to obtaining temporal bones and teaching temporal bone surgery to residents. Any otologist in charge of resident training will appreciate this chapter, as it describes cadaver procedures and is an excellent aid to resident training.

Chapter VI is devoted to results. It is noteworthy that as far as average hearing is concerned, in Type 3 or Type 4 tympanoplasty, hearing is not appreciably helped. However, out of 116 patients, 92 had preoperative discharge and only 9 had post-operative discharge. Dr. Schuknecht's procedures were performed on all comers, except those who were eliminated by the listed contraindications. He actually operated on chronic suppurative middle ear disease without exclusion, even where the chance of functional improvement was small.

The only mild criticism I have is that the viewer that came with the book is not adequate, and I would suggest obtaining a better viewer, one which carries its own lighting batteries.

Dr. Schuknecht's purpose was to show important histopathologic changes in chronic suppurative middle ear and mastoid disease, and to describe the surgery that he has found most helpful. He has accomplished this task admirably. All otologists (whether they follow his technic or not) should have this book at their disposal. This is especially applicable to residents in training. HENRY Z. GOLDSTEIN, M.D.

Blood Diseases of Infancy and Childhood. Ed. 2. Carl H. Smith, M.D. St. Louis, 1966, Mosby. Pp. 799, 85 illustrations. ($22.00)

This second edition, after six years, gives the author the opportunity "to revise much of the text in the light of newer concepts, and to review once more current knowledge in the field."

Among the revisions are the chapters reviewing blood groups, jaundice, the hemolytic anemias, hemoglobinopathies, blood coagulation, and the treatment of leukemia. Newer concepts covered include the role of rubella in congenital thrombocytopenic purpura, amniocentesis, and intrauterine transfusion for the fetus "at risk" with congenital hemolytic anemia, the newer finding in the hemoglobinopathies, particularly in reference to thalassemia.

The tremendous output in pediatric hematology in recent years has been the work of individuals who are in the main biochemists, geneticists, and immunologists. This makes it hard for the clinician to keep up with all the developments. The job of reporting these advances clearly and adequately is monumental. Smith carries it off here and achieves his purpose to "provide information in terms of the needs of the medical student, pediatrician, general practitioner, house staff officer, and laboratory technologist."

The book contains a valuable bibliography, many useful charts, a glossary of chromosomal terminology, and a list of definitions in relation to blood groups. This is the best available text on the subject and is highly recommended. WILLIAM H. FOST, M.D.

Medical Services in the Mediterranean and Minor Theaters. Charles M. Wiltse, M.D. Washington, D.C., 1966, Department of the Army. Pp. 664, illustrated ($5.00)

This volume is one of a quadrilogy comprising an administrative history of the United States Army medical service in World War II. The prologue gives a skeletal description of the medical service in the defense Atlantic bases from along the Atlantic Coast and Caribbean to as far south as Brazil and even Central Africa. A small part of the book deals with the problems of sanitation, prevention and treatment of diseases and injuries, and evacuation at these bases.

Most of the text is devoted to combat medicine from the invasion of North Africa in November 1942 to May 1945. The Mediterranean Theatre demonstrated its importance as a training and proving area for our medical personnel. Fortunately, the casualties were moderate so that our inadequate medical facilities proved sufficient. The problems of evacuation created by the character of the terrain and extremes of climate were remedied by ingenuity and improvisation. The new Mobile Army Surgical Hospital clearing platoons, the availability of psychiatrists at the division level, the availability and early use of plasma, blood, and penicillin, and rapid evacuation by jeep and transport plane were life-saving innovations. Malaria, respiratory infections, gastroenteritis, and venereal disease were the major medical problems. An interesting appendix provides a comparison between German and American medical service.

This book is valuable to those interested in military medicine and to those seeking a complete source of reference to combat medical problems of this theatre. HENRY A. BRODKIN, M.D.

Synopsis of Neurology. Ed. 2. F. M. Forster, M.D. St. Louis, 1966, Mosby. Pp. 218. ($7.50)

Four year's ago, Forster's useful compendium of neurology became available and was swiftly bought, retained, and used by medical students, residents, and GP's throughout the country. This second edition brings up to date both newer knowledge of treatment and newer technics of diagnosis. We are taken in orderly fashion through examination methods, special diagnostic tests (including electromyography and contrast roentgenology), and the various clinical entities — tumors, trauma, infections, vascular disorders, and so on. The author wastes no words, does not involve his reader in controversy, but presents the material in lean and crisp fashion. The chapter on headache is a monograph by itself, one that will be useful to any physician. The book is flexibly bound and will fit comfortably into a large coat pocket. It is a remarkably concise and useful presentation of a complex subject.
ABRAHAM LEFF, M.D.

Psychology For Psychiatrists. C. G. Costello, Ph.D., Long Island City, 1966, Pergamon Press. Pp. 328. Softback. ($3.75)

A book by a psychologist beamed at psychiatrists might sound like a display of *chutzpah*. The physician's immediate reaction would be to analogize this to a text for obstetricians written by a midwife. This, however, is unfair. Actually, Professor Costello helps fill in the gaps in the average psychiatrist's training in statistics, research design, testing technics, and in such basic psychologic concepts as arousal mechanisms, rating scales, perception, and the like. The author does not go deeply into the clinician's realm. The reader may feel heckled by the 850 citations in the bibliography, but this rich roster does open the door to the doctor who wants to follow a trail suggested by Professor Costello. What the author does is to abstract crucial studies, or report path-finding experiments in many areas of psychology, so that the reader gets some highly condensed information — and is then told where he can get the details. In this sense, this text is a kind of notebook. The psychiatrist typically feels that his base science is medicine not psychology — and for this reason often gives only a once-over-lightly to psychologic concepts. This handy little book will serve as a corrective to this causalness. The style is readable, fluent, and free of pomposisness. HENRY A. DAVIDSON, M.D.

Eye And Brain. R. L. Gregory, Ph.D. New York, 1966, McGraw Hill. Pp.251. Softback, illustrated ($2.45)

Most psychologists these days seem to be especially interested in clinical problems. It is unusual to find a work by a psychologist (Dr. Gregory is with Cambridge University in Britain) which concentrates on physiology rather than on psychiatry. Here is a well-written, wonderfully illustrated, and highly readable account of how we learn how to see, how our perceptual system develops, how illusions and spatial distortions occur, how artists and photographers portray three dimensions on a plane, how and why some figures are really "disturbing" — and even how the absence of gravity and the presence of specialized hazards might affect the visual efficiency of men in orbit or in space ships. ULYSSES FRANK, M.D.

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If you do not bind your JOURNALS, use the table of pages (below) to find the month of issue to which any page citation refers.

The annual reports of the committees and officers of the Society and the Transactions of the annual meeting appear in the August issue.

TABLE OF PAGES

January	1 to 38	August	279 to 408
February	39 to 76	September	409 to 448
March	77 to 114	October	449 to 494
April	115 to 152	November	495 to 542
May	153 to 184	December	543 to 578
June	185 to 222	Bicentennial	July JOURNAL
July	223 to 278	Annual Reports and Transactions	August JOURNAL

A

Abortion, Letter Concerning 443
Academy of Medicine 100
  Library Acquisitions 565
  Meetings 554
Accidents and Medication e496
Ackerman, Milton, M.D.; Atlantic City *465
Administrative Secretary-Convention Manager e279
Advertisements Worth Reading ab505
Advertising 50 Years Ago c77
Advisory System for Medical Review—Featherston *423
Africano, Scipio H.† 439
Aged, Care Of br491
Agonizing Experimental Dilemma e280
Air Pollution 60
Anderson, William A., M.D.; Orange *161
Animal Bites, Treatment of—Kandle *79
  Crackers e154
Announcements 33, 71, 108, 148, 192, 441, 490, 535
Annual Meeting Attendance 408
  1966 Program 117
  1966 Reports 283
  1967 Tentative Program 534, 567
Another Plague Passes e450
Anti-Poverty Program 172
Aorta Catheterization For Thoracic Aortography—D'Ambrosio *462
Appel, James Z., M.D., Address of 237
Appetite Suppressant—Feldman *454
Arteriography br540
Arthritis and Bursitis, Betamethasone in—Haines *155
Arthrography—Chirls *61
Asthma Complicated by Foreign Body—Mattioli *551
Athletic Injury, Prevention of—Tomlins *414
Atkinson, Sam C., M.D.; Summit *168

B

Baker, Augustus L., Jr., M.D.; Dover *502
Baldness, Boldness About e409
Bar Association, Cooperation With 431
Barnard, Robert D., M.D.; Lakewood 109
Bane, Arthur E., M.D.; Philadelphia *256
Bedrick, John J., M.D., Address of 273
Bee Stings e153

1- 38—Jan.	153-184—May	409-448—Sept.
39- 76—Feb.	185-222—June	449-494—Oct.
77-114—March	223-278—July	495-542—Nov.
115-152—April	279-408—Aug.	543-578—Dec.

Bekampis, Eugene† 488
Bergen County, Early History of 30
Berkhout, Peter G.† 488
Betamethasone in Arthritis and Bursitis—Haines *155
Bicentennalia 29, 68, 107, 146, 179, 276
Bicentennial Commemorative Issue e224
General Assembly 226
Pictorial Review 242
Schedule 35
Scientific Session 256
Souvenirs 472
Bignami-Marchiafava Disease—Feldman *51
Biliary Passages, Surgery of br445
Biochemistry, Comparative br112
Biological Distributing Stations ab82
Biotelemetry e39
Blakemore, William S., M.D.; Philadelphia *256
Bleeding in Bowel Disease—Friedman *57
Bleeding in Varices and Hiatal Hernia—Blakemore; Nusbaum; Baue *256
Blood Diseases of Infancy and Childhood br570
Pressure: A Problem in Hydraulic Engineering—Harmon *477
Bogdonoff, Morton D., M.D.; Durham, North Carolina *522
Book Reviewers, Information for 109
Book Reviews 72, 110, 149, 181, 218, 445, 491, 538, 569
Borsher, Irving P., M.D.; Newark *498
Bowel Evacuant—Statman *95
Brain Damage, Diagnosis of—Widrow *47
Injured Children, Organization of ab94
Thyroid Relationships br74
Vascularity of br112
Breast Engorgement, Suppression of — Reisfield; Paret *458
Brown, J. Carlisle† 35
Burns, Treatment of ab501
But Especially This Year e115

C

Camche, Leon J.† 568
Cancer, Endometrium ab501
Gynecologic—Keating *89
Regression of br538
Caracta, Antonio R., M.D.; Perth Amboy *45
Carbohydrate Metabolism in Infancy br539
Carbon Dioxide Therapy in Dermatology—Atkinson *168
Cardiology For Nurses br491
Cardiomyopathies br73
Care For The Aged br491
Cataract Surgery, Atlas of br110
Catlaw, J. Kenneth† 568
Cerebral Vascular Accident, Rehabilitation in—Martucci *11
Chairmen, Councils and Committees 53, 88, 236, 461
Character, Good (in Professional Fitness) e225
Charity, The Denigration of e153
Chirls, Marvin, M.D.; East Orange *61
Choledochal Cyst Simulating Biliary Atresia—Spiro *163
Claims Against Physicians—Featherston *423
Civic Appraisal (of MSNJ)—Hughes *226
Cold, Common 76
Coles, Abraham, M.D. 107
Colonic Bleeding and Sigmoidoscopic Differentiation—Edson *3
Colour Vision br446
Commemorative Issue, Bicentennial e224
Committee Members, Liability of 425
Committees and Councils 435
Special 484
Communicable Diseases 25
Community and Racial Crisis br492
Compensation of Physicians 427
Complement br72
Component Societies, Officers of 438
Condylomata Accuminata Associated with Carcinoma—Litvak; Melnick; Lieberman *165
Confidential Communication e544
Congenital Dextrocardia and Situs Inversus Totalis—Intharakoses *159
Connective Tissues, Congenital Disorders of br492
Constitution and Bylaws 528
Revision of 527
Cook, Edgar L., M.D.; Belle Mead *83
Corpus Callosum, Function of br72
Cost Per Pill e450
Costello, John L., M.D.; Jersey City *54
County Presidents Meeting 25
Current Diagnosis br492
Cystic Duct Syndrome—Kohn *86

D

D'Ambrosio, Victor, M.D.; Murray Hill *462
Death Certificates, Delay in Signing 144
Dependents' Medical Care 425
Dermatology, Carbon Dioxide Therapy in—Atkinson *168
Diabetes, How to Live with br72
Juvenile br111
Latent Detection of—Haynes, Jr. *469
Diagnosis, Current br492
Dinner-dance, 1966 Bicentennial Meeting 253, 266, 272
Disability Reports: Social Security e40, ab56
Discrimination Against Members 431
Doctor Means A Learned Man . . . Or Does It? e1
Doctor-Patient Relationships—Osmond *512
Driver Reaction Patterns 483
Drug Addiction 174
Jungle, Finding Way Through e77
Safety Report br150
Drugs, Cost of ab415
New br110, br445
of Choice: 1967 br569
Reactions Invited 145
Dukes, Howard R.† 180
Duty To Become Involved, The e115
Dwyer, William A., Jr., M.D.; Paterson *451

E

Each Year Adds Something e1
Edson, James, M.D.; Paterson *3
Electrocardiography, Pediatric br110
and Vectorcardiography br149
Elliott, Frazier J.† 35
Emergency Room, Non e410
English, Thomas D., M.D. 179
Epidemiology, Studies in br111
Extrasensory Perception br446
Eye and Brain br570
Surgery, Atlas of br110

*—Original Article
†—Obituary
e—Editorial
br—Book Review

ab—Abstract
Bicentennial: July JOURNAL
Annual Reports: August JOURNAL
Transactions: August JOURNAL

F

Featherston, Daniel F., M.D.; Asbury Park ..... *423, e544, †568
Feldman, Harold S., M.D.; Livingston *51, *454
Financial Barriers to Medical Study e449
Fishbein, Morris, M.D.; Chicago, Illinois *228
Food Facts for Teenagers br150
Fort, George Franklin, M.D. 68
Fractures of Soft Tissue Injuries br112
Friedman, Abraham I., M.D.; Hackensack *57
Future Physicians' Clubs 27

G

Gastric Bezoars—Park; Todd *17
Gastroenterology br445
Gastrointestinal Bleeding, Symposium on 256
General Session 391
Generic Drug, Opinion on 99
Genitourinary System—Radiographic Atlas br540
Gerard, Franklyn P., M.D.; Newark *506
Give and Take br74
Glazier, Marion e225
Gloucester County, History of 69
Goldberg, David† 147
Golden Merit Award 274
Gonadotropins br445
Gordon, Katherine K., M.A.; Englewood *41
Gordon, Richard E., M.D.; Englewood *41
Gout, Booklet on 536
Governor of New Jersey, Address of 226
Governor William Augustus Newell 146
Griseofulvin and Lupus Erythematosus—Anderson; Torre *161
Groin Dissection br112
Gross, Mason W., Ph.D., Address of 267
Group Psychotherapy—Cook *83
Gurshman, Sol† 439

H

Haase, F. Robert, M.D.; Neptune City *418
Haines, Keith E., M.D.; Camden *155
Handicapped, Employment of 141
Harmon, Arthur R.; Port Republic *477
Hashish: Its Chemistry and Pharmacology br182
Haynes, William F., Jr., M.D.; Princeton *469
Healing Art, The 144, 275, 434, e495, br538
Health Care Demands—Bogdonoff; Nichols *522
Health Education, Federal Assistance in 50
Hearing in School Children—Sophocles; Muzzarelli *92
Heart, The br491
Disease, Social Security Reports for—Zucker *8
Hemopneumothorax, Spontaneous—Gerard; Sabety *506
Hernia, Obturator—Dwyer, Jr. *451
Hirsch, Erwin O., M.D.; Perth Amboy *45
Historical Appraisal (of MSNJ)—Fishbein *228
History of MSNJ 144, br538
History of Medicine Exhibits 138
Homemaking for the Handicapped br492
Homosexuality, Sociologic Aspects of br181
Honor A Physician?—Osmond *512
Hughes, Governor Richard J., Address of 226
Hydraulic Engineering and Blood Pressure—Harmon *477
Hypnosis Course 550

I

Icarus Syndrome e543
Illegitimacy br181
Information for Readers ab422
Insect Bite, Don't Laugh Off the e153
Internal Medicine, Controversy in br182
Interns and Residents, Payment of 530
Intharakoses, Annop, M.D.; Trenton *159
Introcaso, D. A., M.D.; Clark 443
Iron Poison Antidote ab490

J

Jehl, Joseph R., M.D.; Clifton e224, *441
Jet-Propelled Smallpox e116
Johnson, President (of U.S.) Lyndon B., Message from 223
Joints, Examination of br73
JOURNAL Advertising Rates 426
Contributors, Information for 46
New Cover e2
Salutes, The e2

K

Kahn, Keith† 537
Kandle, Roscoe P., M.D.; Trenton *79
Kaplan, Herman† 439
Keating, Garrett M., M.D.; Plainfield *89
Kellerman, Edwin, M.D.; Atlantic City *465
Kiely, Eugene M.† 180
Klippel-Trenaunay-Parkes Weber Syndrome—Wortzel *420
Kohn, Norman N., M.D.; Cinnaminson *86
Koslow, William† 488

L

Lasker, Norman, M.D.; Hillside *545
Lee, Benjamin F.† 489
Legg, George Edward† 439
Legislation, Current State 428
New Jersey 561
Legislature Congratulates MSNJ 278
Liaison Representatives 484
Library Acquisitions, Academy of Medicine 565
Litigation and Rehabilitation—Smith *473
Lens, Symposium on br445
Letters to THE JOURNAL 109, 443, 534
Leukemia 109
Liability Coverage Rates 425
Professional 102
Licensure Examinations br110
Lieberman, Paul R., M.D.; Long Branch *165
Litvak, Austin S., M.D.; Long Branch *165
Lying, The Importance of br149
Lymphangioadenography—Keating *89

1- 38—Jan.
39- 76—Feb.
77-114—March
115-152—April
153-184—May
185-222—June
223-278—July
279-408—Aug.
409-448—Sept.
449-494—Oct.
495-542—Nov.
543-578—Dec.

M

Madden, Edith Soden e279
Malpractice Claims 141
  Factors Affecting 102
Manette, Milton† 106
Marchiafava-Bignami Disease—Feldman *51
Mattioli, Elmer N., M.D.; Vineland *551
Maurer, William R., Jr., M.D., New Post for 103
McCarthy, Arthur M.† 70
Measles Vaccine 172
Medical Approach to Upper Gastrointestinal Bleeding—Tumen *260
  Education, Federal Assistance in 50
  Practice, Current Concepts in br72
  Review and Advisory System—Featherston *423
  School in New Jersey 101
  Science and Scientism e78
  Services in the Mediterranean and Minor Theaters br570
  Student Loan Fund Contribution 173
Medical-Surgical Plan, Early History—Borsher *498
  Open Discussion on 404
Medicare, Billing for 529
  Forms 176
  Program 26
  In State Institutions 531
Medication and Accidents e496
Medicine and Psychiatry br182
Melnick, Irving, M.D.; Long Branch *165
Membership Directory 36a(March), 52a(April), 175
Mental Retardation, The Biosocial Basis of br150
Merck Manual br539
Methadone Is A Narcotic 67
Meyer, George P.† 439
Microcosm: Centennial Epic 107
Microspherule and Salicylates—Tillis *416
Moriarty, John F.† 440
Moya, Frank, M.D.; Miami, Florida *552
Muzzarelli, Robert A.; Trenton *92

N

Narcotics br112
  Addiction 174
Narrative Disability Reports e40, ab56
Nevin, Citation to Richard I. 434
Newell, William Augustus 146
Newborn, Diseases of br149
Nichols, Claude R., M.D.; Durham, North Carolina *522
Noguera, Julio T., M.D.; Neptune City *418
Nominations and Election, 1966 390
Non-Emergency Room e410
Novak, Edward J.† 35
November is Life Month e497
Nurses on Horseback ab10
Nusbaum, Moreye, M.D.; Philadelphia *256

O

Obituaries 35, 70, 106, 147, 180, 439, 488, 537, 568
Obstetrics br110
Obturator Hernia—Dwyer, Jr. *451
One Hundredth Anniversary Meeting 32
Ophthalmology br74
  and the Pediatrician br540
Opticians' Attitude Toward S-2658 24
Osmond, Humphry, M.D.; Princeton *512
Ownership Statement 531

P

Padilla, Elena, Ph.D.; New York, New York *519
Padney, Edward V.† 180
"Pap" Smear Kits 176
Paret, Frank L., M.D.; New Brunswick *458
Park, Sang Chong, M.D.; Ridgewood *17
Parotid Gland, Surgery of br150
Pastras, Thomas† 568
Pathology, History of br111
Pediatric Therapy br181
Pediatrics and Psychiatry—Calobrisi; Kim; Ganss *21
Pediatrician, Ophthalmology for br540
Pen is Mightier e409
Phlegmasis Cerulea Dolens—Costello *54
Phonocardiography br73
Phony Directory Solicitations 28
Physicians Placement 105, 532
Pictorial Review of Bicentennial Meeting 242
Plagues, Return of e495
President, Address of Retiring 273
  Our New e224
  (U.S.), Message from 223
Prevention of Athletic Injury—Tomlins *414
Professional Fitness, Good Character as Part of e225
Psychiatric Therapies br111
Psychiatry, Introduction to br74
  and Medicine br182
  and Pediatrics—Calobrisi; Kim; Ganss *21
  Synopsis of br74
Psychology for Psychiatrists br570
Psychoneurosis and Schizophrenia br492
Psychotherapy br446
  and the Behavior Sciences br491
  Short Term—Gordon; Gordon *41
Public Health, World of br72
Pulmonary Edema—Hirsch; Caracta *45

R

Racial Crisis and the Community br492
Radiographic Atlas of Genitourinary System br540
Reason, John J.† 70
Reference Committees, 1966 375
Rehabilitation in Cerebral Vascular Accident—Martucci *11
  Literature 536
  of Disabled Worker—Smith *209, *473, *509, *558
Reisfield, Donald R., M.D.; New Brunswick *458
Renal Biopsy—Kellerman; Ackerman *465
  Insufficiency—Lasker *545
Resnick, Solomon† 537
Respiratory Care br181
  Diseases Abstracts 36, 75, 113, 151, 183, 221, 447, 493, 541, 577
Resolutions, 1966 357
Resuscitation of Depressed Newborns—Smith and Moya *552
Road Ahead, The—Jehl *411
Roentgenology, Principles of Chest br149
Rogers, Fred B , M.D. 104
Rutgers Anniversary e39

*—Original Article
†—Obituary
e—Editorial
br—Book Review
ab—Abstract
Bicentennial: July JOURNAL
Annual Reports: August JOURNAL
Transactions: August JOURNAL

S

Sabety, Adrian M., M.D.; East Orange *506
Salicylates and Microspherule—Tillis *416
Schizophrenia and Psychoneurosis br492
Schrack, Helen F.† 440
Schultz, Augustin M.† 489
Scientific Appraisal (of MSNJ)—Appel *237
Program, Annual Meeting 124
Scientism and Medical Science e78
Second Injury Fund 141, 534
Sesquicentennial Six e1
Sex and the College Student br538
Sexual Behavior in Human Female br446
Shaw, Ernest† 35
Shlionsky, Herman† 440
Sigmoidoscopic Differentiation of Colonic Bleeding—Edson *3
Silverstein, Benjamin† 489
Singer, Max† 489
Smallpox, Jet-Propelled e116
Smith, Bradley, E., M.D.; Miami, Florida *552
Smith, Jarvis, M.D.; Trenton *209, *473, *509, *558
Smith, Lyndon A., M.D. 29
Smoking and Respiratory Performances ab521
Smoking in Children—Steel *555
Social Phenomena and the Physician—Straetz; Padilla *519
Security Disability Reports e40, ab56
Security Reports for Patients with Heart Disease—Zucker *8
Sophocles, Aris M., M.D.; Trenton *92
Souvenirs, Official Bicentennial 241
Spiro, Alfred J., M.D.; Philadelphia *163
Spirometry ab521
Spontaneous Regression of Cancer br538
Sprague, Edward, M.D., Role in MSP—Borsher *498
State Activities 23, 65, 99, 141, 171, 425, 461, 484, 527, 561
Statman, Arthur J., M.D.; Irvington *95
Steel, Paul H., M.D.; Atlantic City *555
Stereoscopic Atlas of Mastoidotympanoplastic Surgery br569
Stern, Morton M.† 440
Straetz, Ralph, M.D.; New York, New York *519
Supervision of Medical Rehabilitation—Smith *558
Surgent, George W.† 489
Synopsis of Neurology br570

T

Technical Exhibits 133
Telephone Listings, Ethics of ah508
Therapy, Current br540
Third Century Begins 433
Thoracic Aortography—D'Ambrosio *462
Thyroid Disease, Concepts of hr73
Tillis, Herman H., M.D.; East Orange *416
Todd, James S., M.D.; Ridgewood *17
Tomlins, Francis I., M.D.; Ridgewood *414
Torre, Douglas, M.D.; Orange *161
Tracheostomy Today—Haase; Noguera *418
Transactions of the 1966 House of Delegates 281
Presenting The e280
Transfusion, Edema Following—Hirsch; Caracta *45
Transplants br74
Trauma, Management of br539
Neurologic Surgery of br110
Travelling Patients 145
Trichobezoars—Park; Todd *17
Trustees Minutes
November 14, 1965 25
November 21, 1965 26
December 19, 1965 65
January 16, 1966 99
February 20, 1966 174
March 20, 1966 171
April 17, 1966 212
May 13, 1966 428
May 18, 1966 426
June 19, 1966 425
August 21, 1966 529
September 18, 1966 527
October 16, 1966 561
Tumen, Henry J., M.D.; Philadelphia *260
Twins br181

U

Ulcer, Peptic, Surgery for—Baker *502
Ulcerative Disease of the Bowel—Friedman *57
Utilization Committees 99, 104, 426

V

Varney, William H.† 70
Viet Nam, New Jersey Doctors to 24
Vision, Subnormal br74
Voorhies, William S.† 440
Vroom, William L. 23, e449, †489

W

Walking Dangers ab413
Weber, John F.† 70
Weigel, Elmer P.† 568
Widows and Orphans Society 91
Widrow, Suzanne A., M.D.; Hanover *47
Williams, William Carlos, Biography of 276
Winn, William M.† 147
Woman's Auxiliary Annual Meeting 140
Wood, Francis A., M.D. 534
Wortzel, Martin H., M.D.; Millburn *420

Y

Yellin, Charles† 537
Your Heart Has 9 Lives br569

Z

Zucker, I. Richard, M.D.; South Orange *8

1- 38—Jan.
39- 76—Feb.
77-114—March
115-152—April
153-184—May
185-222—June
223-278—July
279-408—Aug.
409-448—Sept.
449-494—Oct.
495-542—Nov.
543-578—Dec.

ABSTRACTS

ON TUBERCULOSIS AND OTHER RESPIRATORY DISEASES. ISSUED BY THE NATIONAL TUBERCULOSIS ASSOCIATION

DECEMBER, 1966 • VOL. XXXIX, NO. 10

EMPHYSEMA MORTALITY IN RELATION TO RESPIRATORY FUNCTION

In a cooperative study of fifteen Veterans Administration hospitals, a correlation was found between life expectancy and the degree of physiologic disturbance at the time of entrance into the study. A history of cigarette smoking was given by 96 per cent of the patients.

This investigation was undertaken primarily to relate the life expectancy of patients with chronic obstructive pulmonary disease (COPD) to the pulmonary function of the patient at the beginning of the observation period.

With the cooperation of 15 Veterans Administration hospitals, a prospective study was designed which would insure almost complete followup data. The inter-hospital cooperative study permitted the inclusion of a large number of patients in a relatively short period of time. The patients were from widely separated areas in the United States, and thus the group was representative of the nationwide problem.

Patients with other diseases from which an early death might be anticipated and those with significant cardiac disease (except cor pulmonale) were excluded from the initial selection. Furthermore, patients were admitted to the study only if the ratio of their residual volume (RV) to total lung capacity (TLC) was 35 per cent or greater, and their TLC was greater than 80 per cent of predicted normal value. These requirements were met by 487 patients between October 1957 and July 1960.

The group was arbitrarily divided into three categories of ventilatory abnormality on the basis of the absolute value of the forced expiratory volume in 1 second (FEV_1): an FEV_1 of >1.49; 0.5 to 1.49; and <0.5 L. This pulmonary function test was chosen as the principal method for describing the degree of ventilatory insufficiency because it has been shown to correlate well with other measurements of ventilatory disturbance and because it is now widely used in evaluating patients in hospitals, doctors' offices, disability examinations, and screening programs for respiratory disease.

The mean age of the patients was 57.8 years. The relation of FEV_1 to age was not significant, but a significant decrease in mean weight occurred with decreasing FEV_1. More than half of the patients had a history of pneumonia, some also had other serious pulmonary disease. Only 12.5 per cent denied all previous major pulmonary diseases.

Smoking a Factor

As for smoking, 96.4 per cent of the patients were or had been cigarette smokers — 71.1 per cent were still smoking. Medium and heavy smokers were distributed similarly among the three FEV_1 categories. When the distribution of patients with different smoking habits within each of the FEV_1 categories was calculated, it was found that patients with a severe ventilatory defect usually had smoked for more than 35 years.

In the number per year and total weeks of involvement, the incidence of prolonged respiratory tract infections was high. Five or more infections per year were reported by 33.3 per cent and ten or more weeks of infection per year were reported by 20.3 per cent. There

Attilio D. Renzetti, Jr., M.D., John H. McClemnt, M.D., and Bertram D. Litt. *The American Journal of Medicine*, July, 1966.

was little if any correlation between FEV_1 category and number or duration of these infections.

The group with an FEV_1 >1.49 included a significantly higher proportion of patients who did not wheeze than did the other two groups.

Mortality Rates

At four years of follow up, the cumulative mortality rate, computed by the life-table method, for the 487 patients was 53 per cent. This is in contrast to the four-year cumulative mortality rate for 58-year-old white men in the United States which in 1961 was 8.3 per cent.

The mortality rate for 98 patients with FEV_1 >1.49 L was 26 per cent at four years. For 320 patients with FEV_1 of 0.5 to 1.49 L it was 44 per cent at four years; and for 64 patients with FEV_1 <0.5 L it was 89 per cent at four years. FEV_1 was not measured in five patients.

Mortality rates in the group with cor pulmonale were much higher than those of the other groups in the first two and a half years. However, by four years the patients with carbon dioxide retention but not cor pulmonale had a death rate almost identical with that of the cor pulmonale group.

Of the 487 patients, 83 had an additional major disease. The diseases included tuberculosis, silicosis, bronchiectasis, bullae, and pulmonary surgery. There were no significant differences in mortality betwen these patients and the others in the group.

When patients from two hospitals between 4,000 and 9,000 feet above sea level were compared with the others, it was found that those at the higher altitudes had significantly lower arterial and oxygen saturations and higher hematocrit values, and that their mortality rates were considerably higher than the others. The incidence of cor pulmonale in these patients was 43 per cent in contrast to 17 per cent in the others.

This study has shown that the prognosis of patients with COPD is significantly affected by the degree of disturbance in gas exchange as estimated from the level of oxygen saturation and pCO_2 in the arterial blood after exercise. When the arterial oxygen saturation was greater than 92 per cent and the pCO_2 lower than 48 millimeters Hg, the four-mortality was 33 per cent; when the arterial saturation was lower than 92 per cent, the death rate was 44 per cent; when both oxygen and carbon dioxide deviated abnormally from these quantities, the mortality rate was 72 per cent.

Long survival after an episode of congestive failure from cor pulmonale in patients whose hypoxemia could be decreased suggests that the high mortality is not due to the heart disease itself. Rather this event may identify patients with advanced pulmonary disease that is to some extent irreversible or is characterized by episodes of severe hypoxemia.

Polycythemia did not affect prognosis, a surprising finding in view of the association of polycythemia, hypoxemia, and cor pulmonale. Since it is known that the volume of packed red cells does not accurately reflect the red cell mass in patients with COPD, this phenomenon may have operated often enough in this group of patients for the presence or absence of an elevated hematocrit value not to be a reliable indicator of those with more severe hypoxia.

In general, the clinical data show that patients with COPD are predominantly white men over 55 years of age with a high frequency of previous pulmonary disease, respiratory tract infection, chronic cough, wheezing, and dyspnea. A history of cigarette smoking in more than 96 per cent of these patients is most impressive and exceeds that which has been recorded for any other condition in which cigarette smoking has been implicated.

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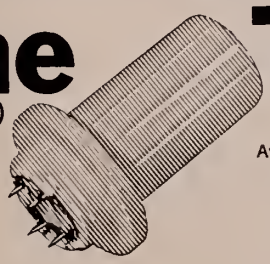
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Breast-feeding and the "modern mother"

Despite a mild resurgence of interest in the importance of breast-feeding a few years ago, many women today do not choose to nurse their young. This is for a variety of reasons—social, economic, cultural and sometimes medical. In such cases the physician's task is to find the most suitable means of preventing lactation and easing the pain of breast engorgement.

The means of therapy

The value of hormone therapy for this indication is of course well established. Both androgen and estrogen are known to inhibit the production and secretion of the lactogenic hormone by the anterior pituitary. As estrogen levels decline sharply at parturition, lactogenesis is established. When androgen and estrogen are administered to the patient before the release of the lactogenic hormone lactation and breast engorgement are usually prevented.

The time of therapy

The time of administration of this combined medication is crucial; it must be given early enough to suppress the pituitary prolactin and last long enough to permit physiologic readjustment during the puerperium. Excellent results are most often seen when therapy is administered before the onset of the second stage of labor.

However, factors other than effectiveness must also be considered. The agent selected should not interfere in any way with parturition, subsequent uterine involution and the restoration of normal ovarian cyclic function. Furthermore, it should not cause rebound breast engorgement or other manifestations of hormonal imbalance.

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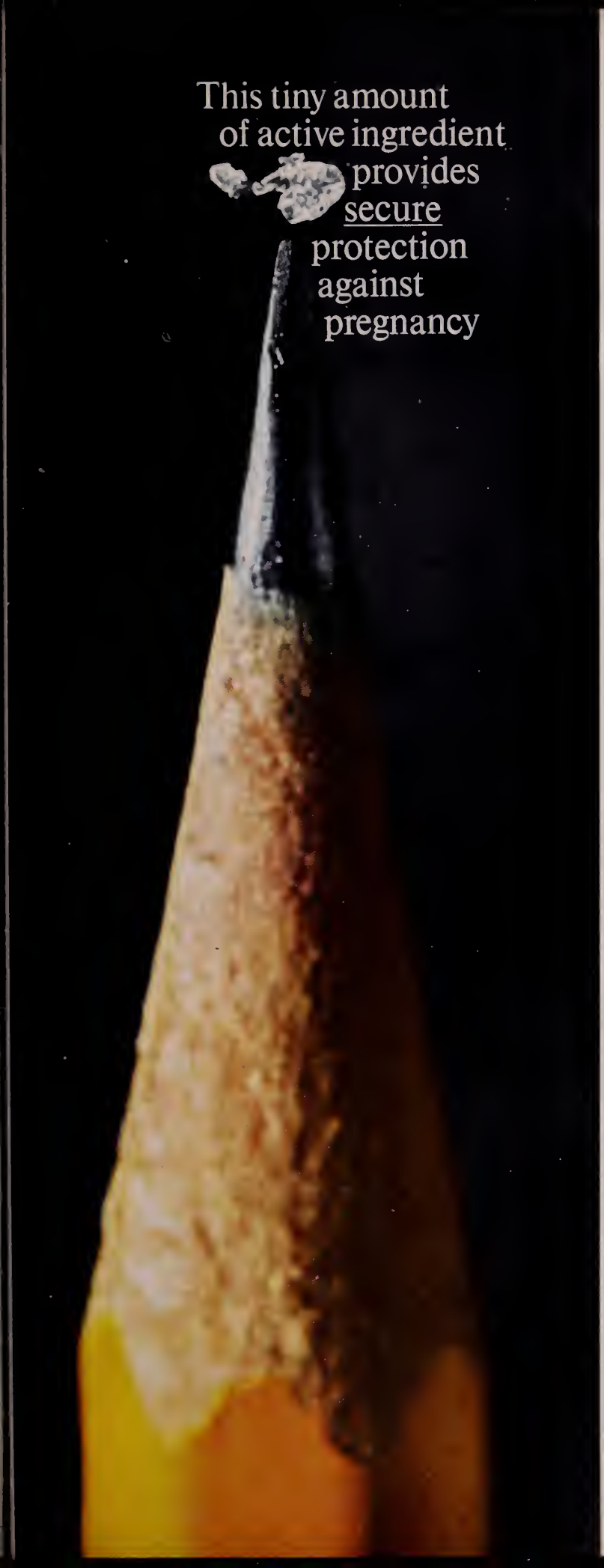
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Warnings—Medication should be discontinued pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. Medication should be withdrawn if examination reveals papilledema or retinovascular lesions. Since the safety of Ovulen therapy in pregnancy has not yet been established, it is recommended that, in a patient who has missed two consecutive menstrual periods, pregnancy be ruled out before oral contraceptive therapy is continued.

Precautions—Because Ovulen may aggravate a tendency toward fluid retention in some patients, it should be administered cautiously to patients with a history of renal or cardiovascular disease (including hypertension), asthma, epilepsy or migraine. Any possible influence of long-term Ovulen therapy on pituitary, adrenal cortical, ovarian, hepatic or uterine functions requires further study. Oral contraceptives also should be administered cautiously to diabetic patients since a decrease in glucose tolerance has been observed in some patients taking these drugs. Patients on Ovulen may occasionally show abnormal glucose tolerance tests, but this does not necessarily indicate the presence of diabetes. Significant increases in platelet count, prothrombin and proconvertin tests, plasma thrombotic activity and plasma proteolytic activity have been reported.

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Patients with a history of psychic depression should be observed carefully during treatment with oral contraceptives, and such treatment should be discontinued if depression recurs to a serious degree. Pre-existing fibroids may increase in size during Ovulen therapy. Such fibroids may regress to pretreatment size after Ovulen is stopped. In the event of breakthrough bleeding the possibility of nonfunctional causes should be borne in mind. Additional means of contraception should be used during the first seven days of Ovulen administration in the first treated cycle, because early ovulation may possibly occur.

Side Actions—The following adverse reactions have been reported with Ovulen; however, a causal relationship to Ovulen administration has not been established in all of the listed complaints: headache, dizziness, depression, breast complaints, amenorrhea, chloasma, vomiting, allergy, edema, migraine, pulmonary embolism, thrombophlebitis, visual difficulties, nervousness, rash, itching, decrease in libido, tiredness, malaise, hair loss and hair growth. A small incidence of nausea, spotting and breakthrough bleeding has been reported; these complaints tend to diminish markedly or disappear after the first cycle of treatment. Some of these side actions have required discontinuance of the drug.

Dosage—One tablet daily for 20 consecutive days beginning 5 days after the onset of menstruation.

Before prescribing see Detailed Product Information, Ovulen.

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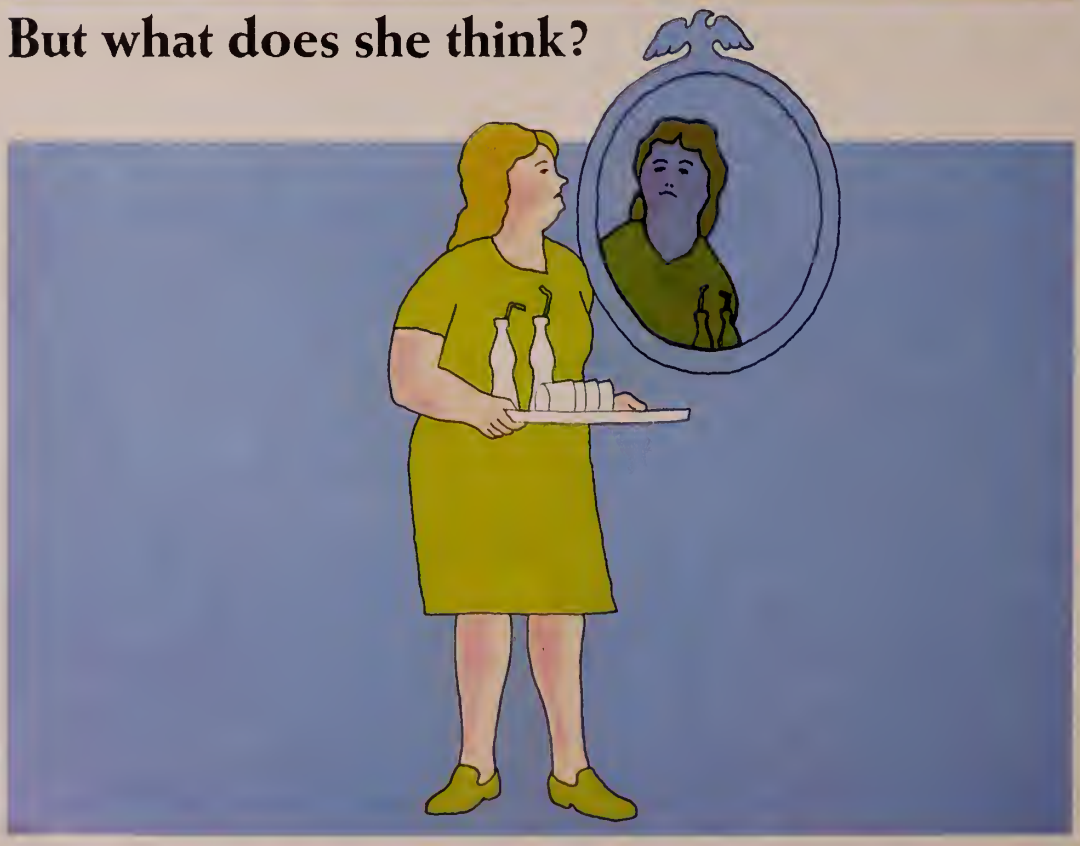
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to help establish a new dietary pattern

Contraindications: Dextro-amphetamine sulfate: in hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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"'Tranquilizer' is not a good word"[1]

"THIS classification is psychologically too seductive, pharmacologically too unspecific, and in terms of results not infrequently untrue."[2]

What is a tranquilizer? According to the 24th Edition of Dorland's Medical Dictionary[3] a tranquilizer is "an agent which acts on the emotional state, quieting or calming the patient without affecting clarity of consciousness."

Defining a drug by its effects, however, can be misleading. The same effects by which the dictionary defines a tranquilizer have sometimes been seen after administration of a sedative — or, for that matter, a placebo.

Ambiguous though the term may be, it appears to be here to stay. The 1966 edition of the Physicians' Desk Reference[4] lists 42 tranquilizers indicated for treatment of anxiety and apprehensive states.

'Tranquilizers' have differences in action, differences in effect

Although all tranquilizers are intended to calm anxious patients there *are* differences in their actions — and in their effects. They have been divided into three categories — the rauwolfia group, the 'minor' tranquilizers, and the phenothiazines.[5]

Although the tranquilizing effect of rauwolfia has been known for centuries, its use as an antipsychotic agent in current practice has diminished.[5]

A 'minor' tranquilizer is often prescribed to achieve more than one effect. Thus, besides being tranquilizers some of these compounds may be muscle relaxants, antihistaminics with some calming action, anticholinergic sedatives, or antispasmodics.[5]

The phenothiazines are considered 'major' tranquilizers because they alter psychotic behavior.[1] This classification may have done them more harm than good because it implies that the phenothiazines should be reserved for the more severely disturbed. This is not necessarily true.

The phenothiazines — and the problem of sedation

One of the problems of prescribing phenothiazines for ambulatory patients has been the fear that excessive sedation will impair the patient's ability to function. This, however, is less of a problem with some of the phenothiazines.

"Clinically they may be differentiated primarily in terms of their potency and the extent of their sedative effect, which appear to be inversely proportional. That is, the least potent, the one which is used in highest dosage, chlorpromazine, is the most sedative, while the reverse holds true for fluphenazine."[6]

In a recent report on various studies conducted over several years evaluating 360 patients treated for anxiety and stress with seven phenothiazines, this inverse relationship of potency to sedation was confirmed.[7] Also under consideration was the degree to which the particular phenothiazines neutralized anxiety (the angolytic index). Interestingly enough there was, again, an inverse relationship. The most sedative of the phenothiazines appeared to be the least active in neutralizing anxiety. Fluphenazine, one of the least sedative, on the other hand, was found to be most effective in relieving anxiety.[7]

RELATIVE SEDATIVE AND ANGOLYTIC INDICES OF PRINCIPAL PHENOTHIAZINES*

DRUG	SEDATIVE INDEX	ANGOLYTIC INDEX	BASED ON STANDARD DOSE OF
Chlorpromazine	100	15	25 mgs.
Trifluprom azine	100	15	25 mgs.
Thioridazine	90	17	25 mgs.
Perphenazine	15	25	4 mgs.
Carphenazine	25	25	25 mgs.
Trifluoperazine	3.3	95	2.0 mgs.
Fluphenazine	3.5	100	2.5 mgs.

*adapted from Sainz[7]

Prolixin is therapeutically effective without excessive sedation

When used as a 'tranquilizer' in general medical practice, in many patients Prolixin (Squibb Fluphenazine Hydrochloride) suppresses anxiety, but not normal activity. These two features are of particular importance to patients who must be able to live and work without their normal daily activities being restricted.

Because of its longer duration of action, Prolixin, in doses of as little as one to three milligrams in adults, generally taken once a day, is effective in maintaining many patients free of their symptoms of anxiety and tension.

Contraindications: Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use with caution in patients with a history of convulsive disorders. Severe reactions may occur in patients with idiosyncrasy to other centrally-acting drugs, and severe hypotension may occur in patients with special medical disorders, e.g. mitral insufficiency and pheochromocytoma.

Precautions: Effects of atropine, anesthetics and C.N.S. depressants may be potentiated. Hypotension may occur in patients undergoing surgery. Do not use epinephrine for treatment of the hypotensive reactions which may appear in patients on phenothiazine therapy.

Side Effects: Extrapyramidal reactions, allergic skin reactions, the possibility of anaphylaxis, drowsiness, visual blurring, dizziness, insomnia, nausea, anorexia, salivation, edema, perspiration, dry mouth, abnormal lactation, polyuria, hypotension, and jaundice and biliary stasis may occur. Routine blood counts are recommended to determine possible blood dyscrasias; if symptoms of upper respiratory infection occur, discontinue drug and institute appropriate therapy.

Available: 1 mg. tablets. Bottles of 50 and 500.

For full prescribing information, see package insert.

References: 1. Simpson, G.M.: Postgrad. Med. 39:557, 1966. 2. Freyhan, F.A.: Am. J. Psychiat. *115*:577, 1959. 3. Dorland's Illustrated Medical Dictionary, ed. 24, Philadelphia, W. B. Saunders Co., 1965, p. 1603. 4. Physicians' Desk Reference, 1966, Oradell, N.J., 1965, p. 310. 5. Cohen, S.: Northwest Med.: 65:197, 1966. 6. Detre, T., and Jarecki, H.: Connecticut Med. *25*:553, 1961. 7. Sainz, A.: Psychosomatics 5:167, 1964.

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Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)

Adults: 2 tsp. 5 times daily (20 mg.)
(or 2 tablets q.i.d.)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

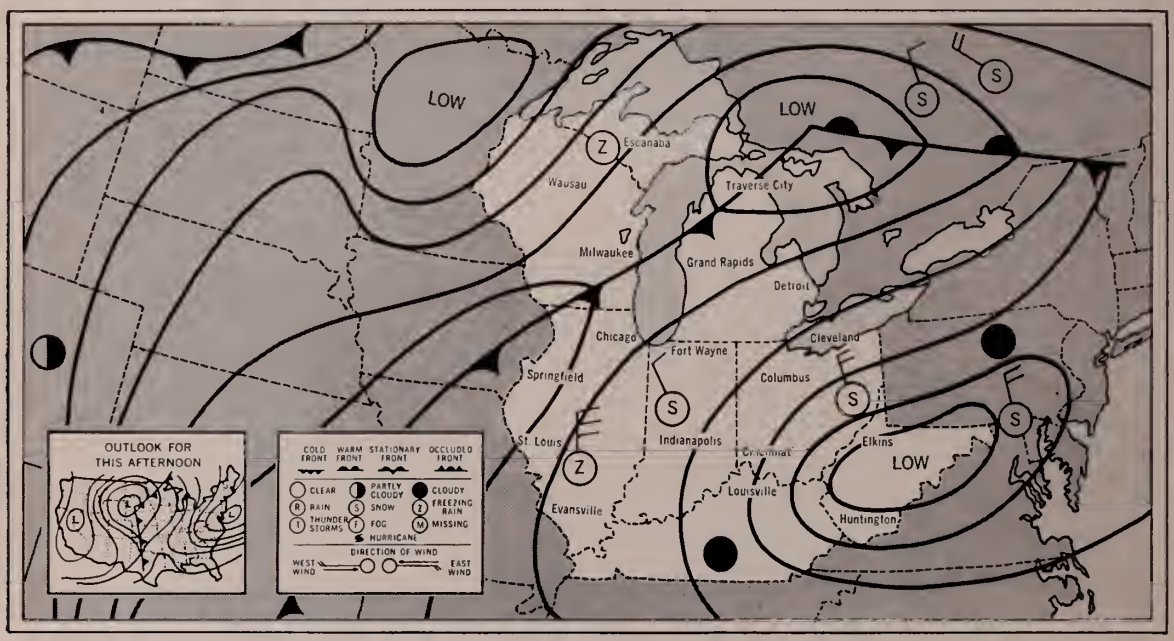
Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

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Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. *Side effects:* Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. *Precautions:* The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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Precautions: Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
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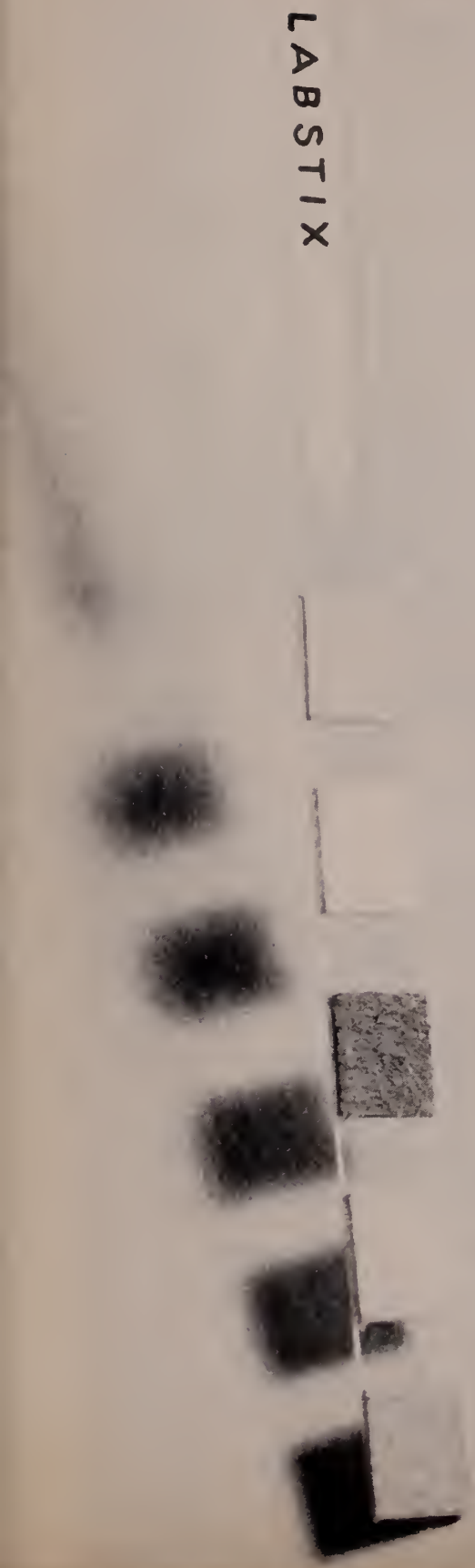
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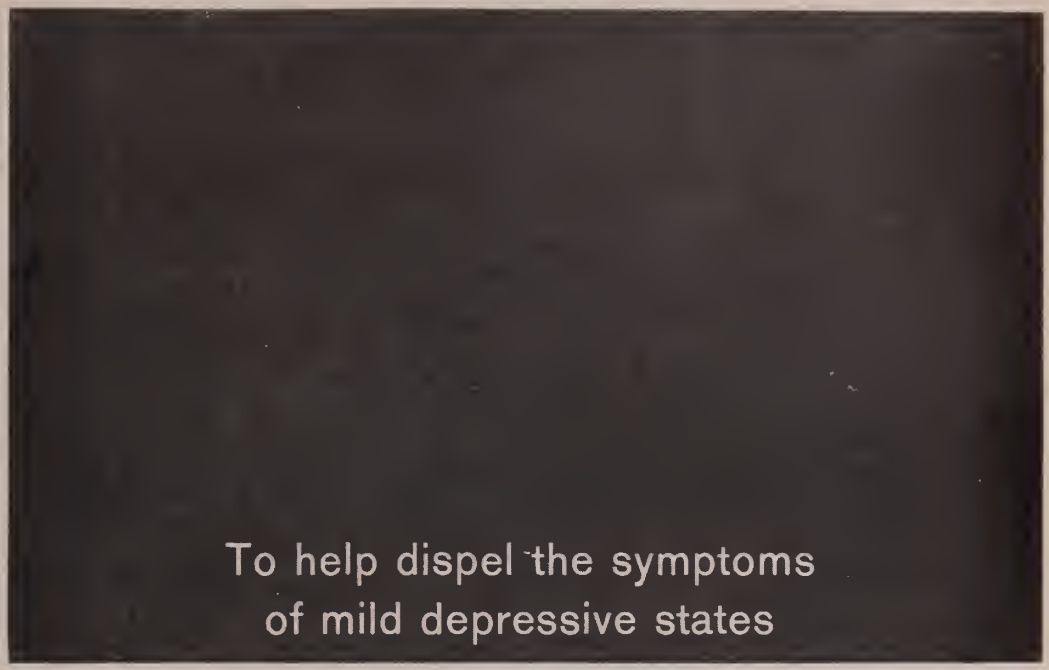
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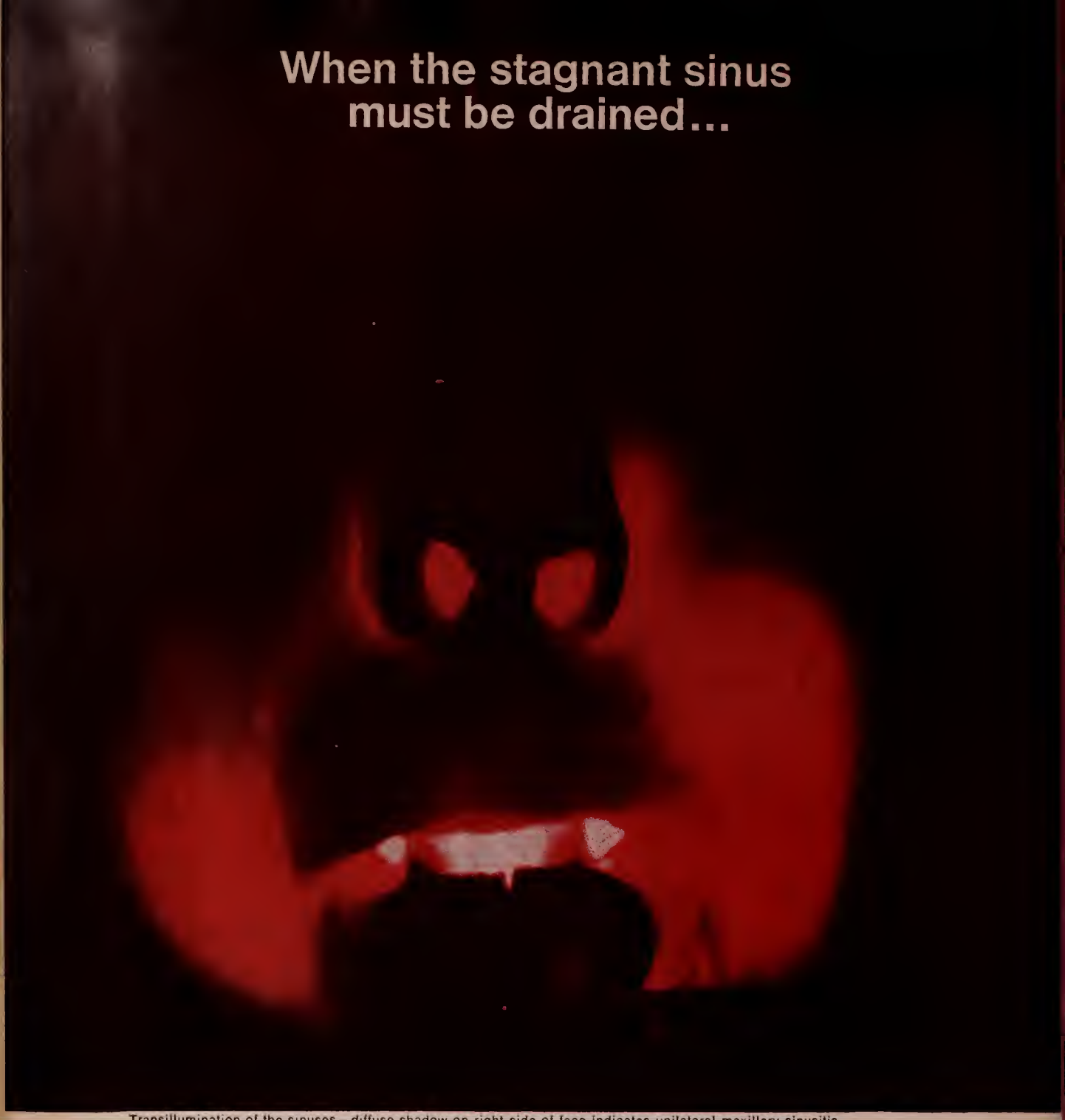
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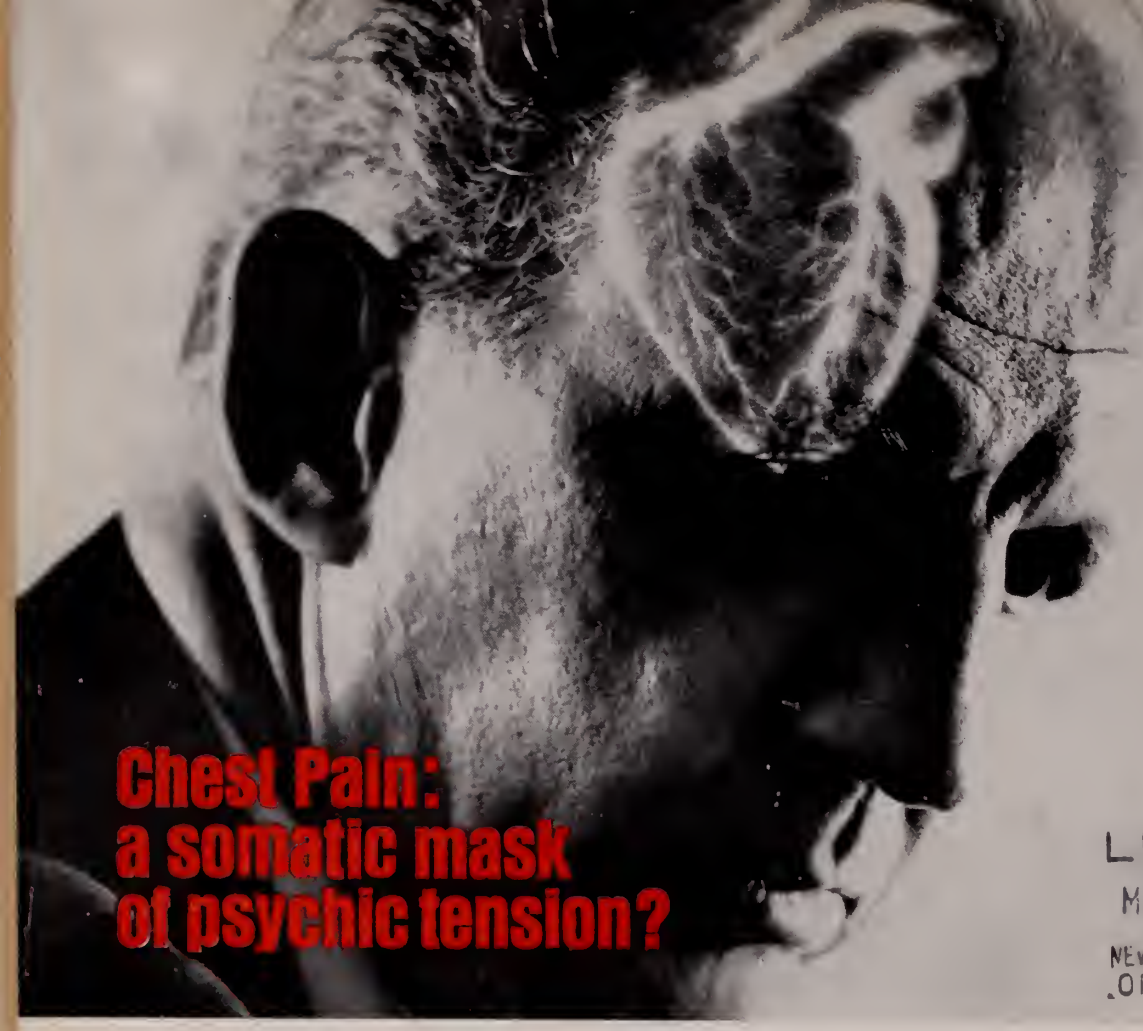
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Chest Pain: a somatic mask of psychic tension?

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"Heart symptoms"—chest pain, tachycardia, arrhythmia—invariably alarm and preoccupy the patient, though they may be completely without organic basis. Such symptoms often are somatic masks of psychic tension, arising from constant encounters with stressful situations.

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Valium (diazepam) is generally well tolerated, and usually does not impair mental acuity or ability to function. If side effects such as ataxia and drowsiness occur, they usually disappear with dosage adjustment.

Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage — Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hrs, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

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